

TERMINATED PREGNANCY REPORT
 INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
 Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
 1. 2003 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
<div> Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ </div> <div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? </div>	<div> Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ </div> <div> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? </div>

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/11/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 12/05/2014 3. 06/12/2015 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. 2014	3. _____	4. _____	5. _____	6. _____

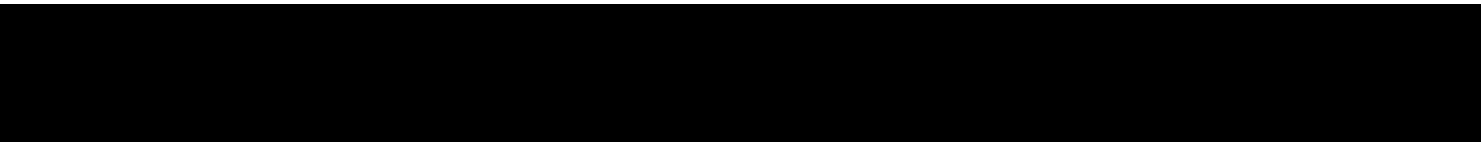
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2009	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2013 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

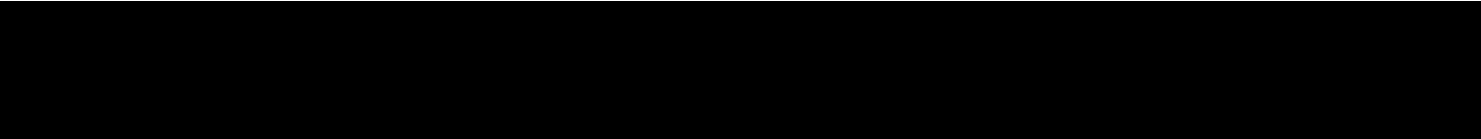
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. 05/08/2015	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 07/16/2009 2. 06/20/2014 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUNDS EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/22/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

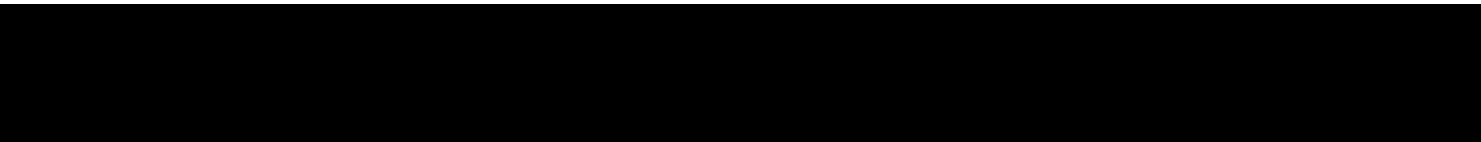
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINTATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

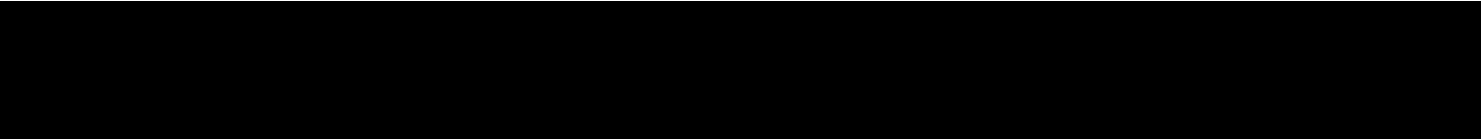
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2005 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2007 2. 01/2013 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/03/2014 2. 07/03/2014 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE,GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 0
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/22/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

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TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

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DATE RECEIVED BY ISDH (*month, day, year*): 01/26/2016

TERMINATED PREGNANCY REPORT
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Per IC 16-34-2

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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/08/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/10/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Master's Degree
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 0
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/03/2015 2. 11/20/2015 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 02/2015	2. 08/2015	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 10/04/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2011 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/18/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2004 3. 2006 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 03/14/2014 4. 07/18/2014 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE,GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/15/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/11/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE,GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION,PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

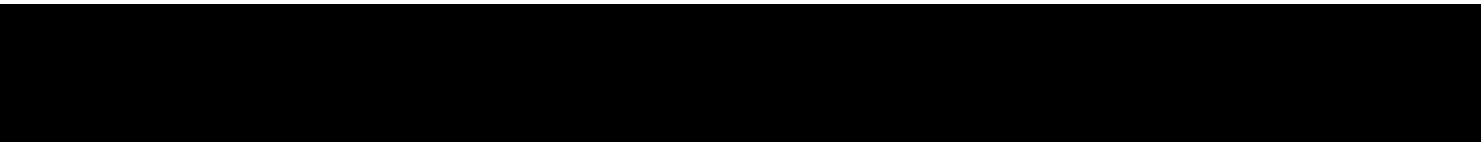
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2015 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1999 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 01/03/2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 01/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 01/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

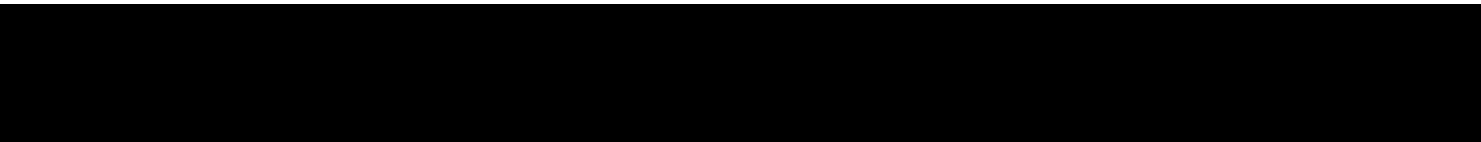
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2002 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/13/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/2015 2. 08/2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1999 2. 2010 3. 2014 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

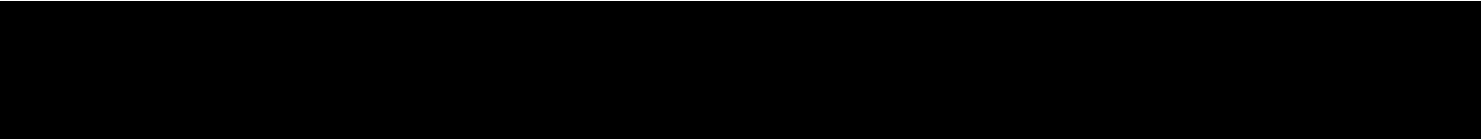
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2011	2. 01/23/2014	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/28/2014 2. 04/02/2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

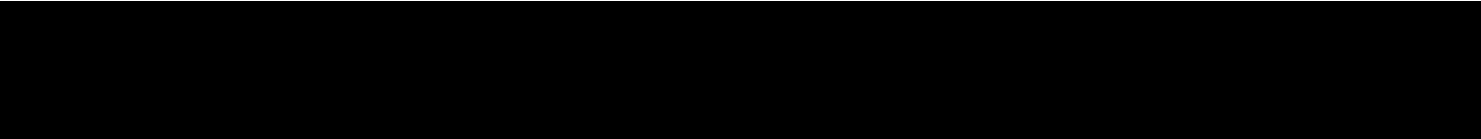
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 0
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/29/2016		Education Master's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

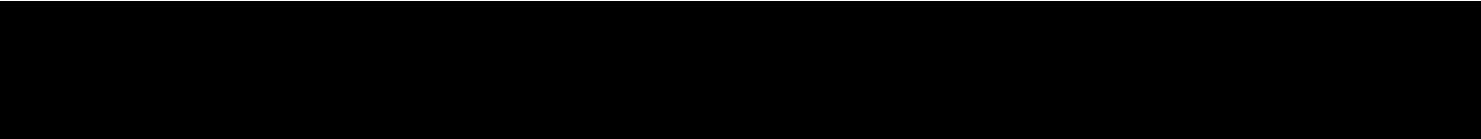
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/22/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 3		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2013 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/29/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2006	2. 2009	3. 2010	4. 2011	5. 2013	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 08/14/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. 2013	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>D&E</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 08/15/2015	Physician estimate of gestation (<i>in weeks</i>) 21	Post fertilization age of the fetus (<i>in weeks</i>) 19
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 09/29/2015	Physician estimate of gestation (<i>in weeks</i>) 14	Post fertilization age of the fetus (<i>in weeks</i>) 12
How were the gestational age and post fertilization age determined? DATE OF INTRAUTERINE INSEMINATION		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 14	Post fertilization age of the fetus (<i>in weeks</i>) 12
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

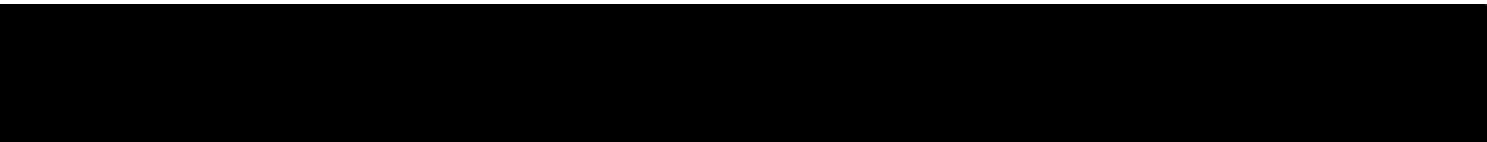
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 13	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

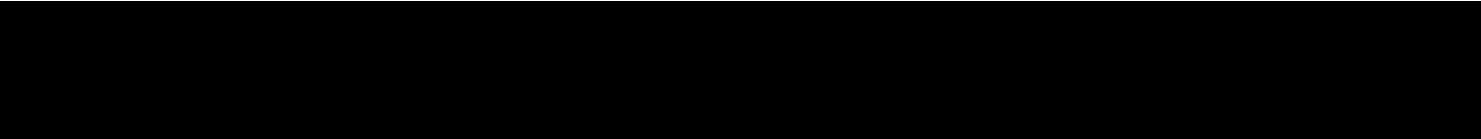
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/08/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/21/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/08/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshtlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/19/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2015 3. 2015 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

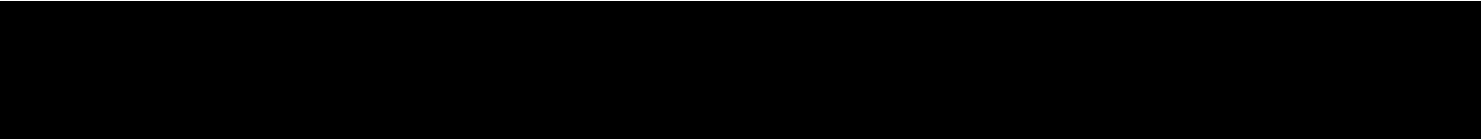
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/09/2013 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 10/09/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

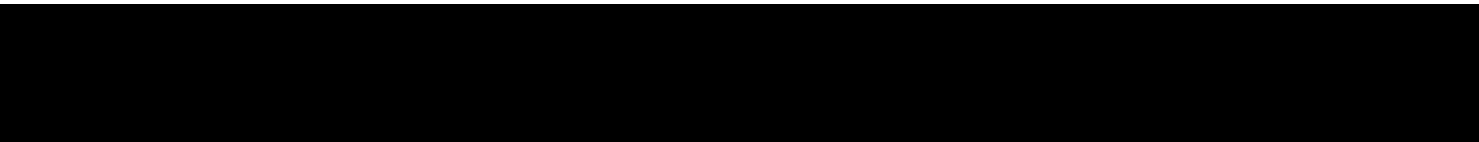
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

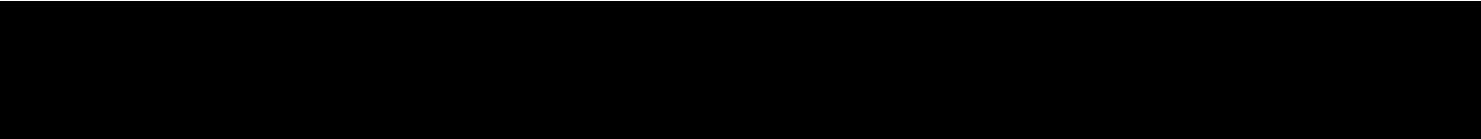
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/17/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

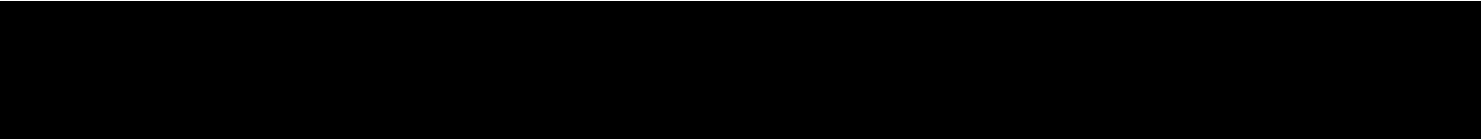
Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/13/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2002 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: , CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/15/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 1

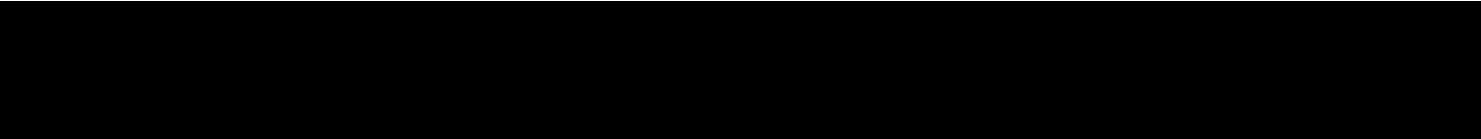
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2012 3. UNKNOWN 4. 03/28/2015 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

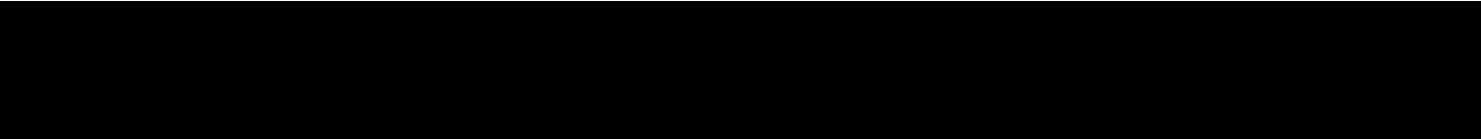
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2009 3. 2010 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

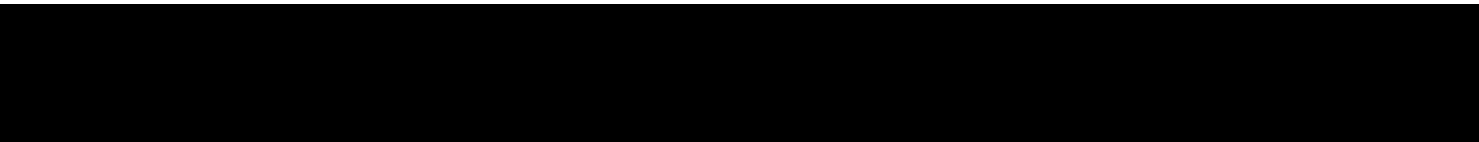
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

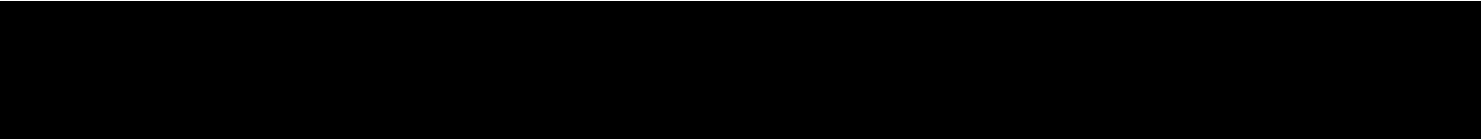
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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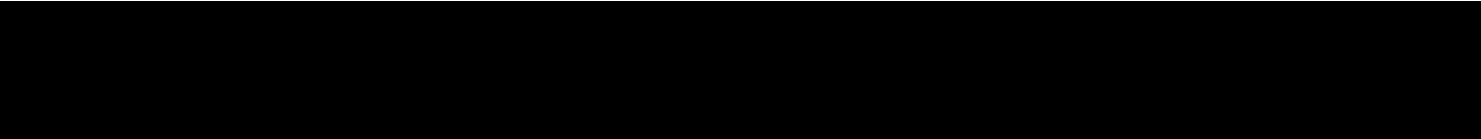
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2008 3. 2010 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

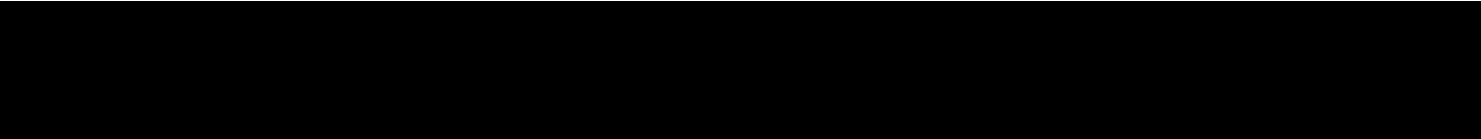
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

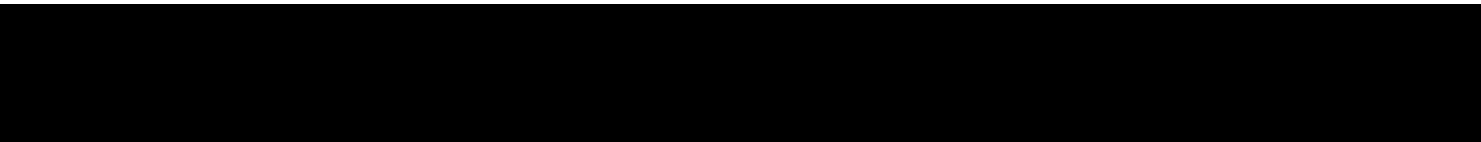
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/26/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/22/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

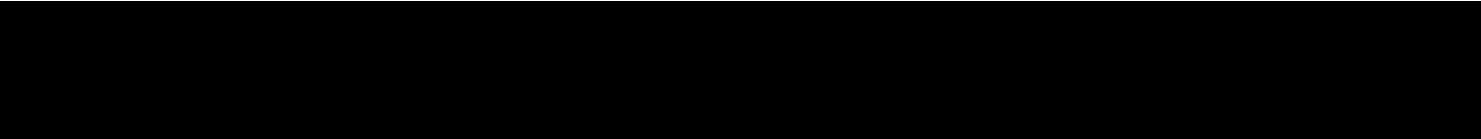
Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 04/09/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

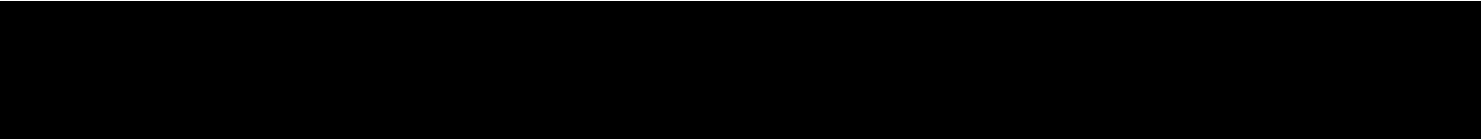
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 07/11/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/31/2015 2. 2009 3. 2013 4. 2005 5. 2002 6. _____			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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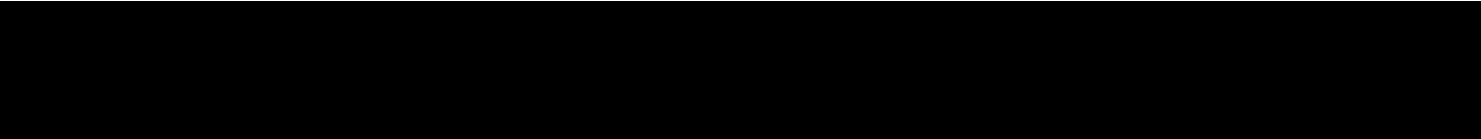
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/23/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 2

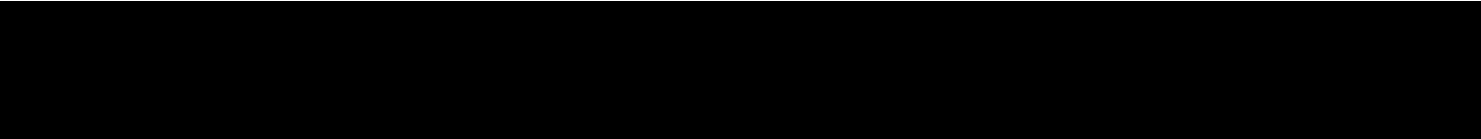
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 1994	2. 1993	3. 2007	4. 2010	5. 2012	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC,CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/16/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

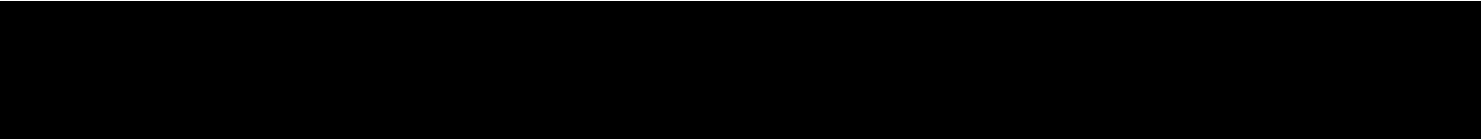
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC,CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2011 3. 2009 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

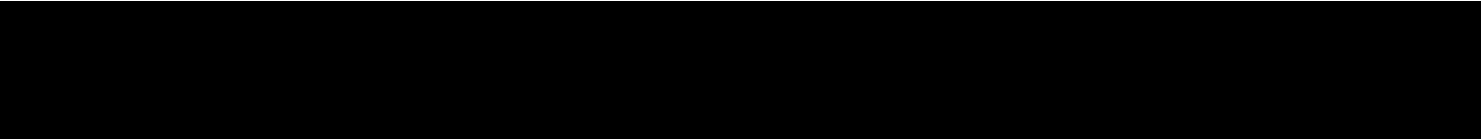
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2004 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 41		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/15/2016		Education Unknown	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2002 3. 2014 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

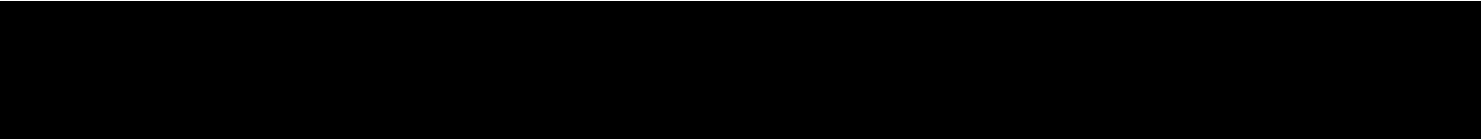
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2011 2. 01/01/2013 3. 01/01/2014 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 10/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/16/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/26/2015 2. 2010 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/08/2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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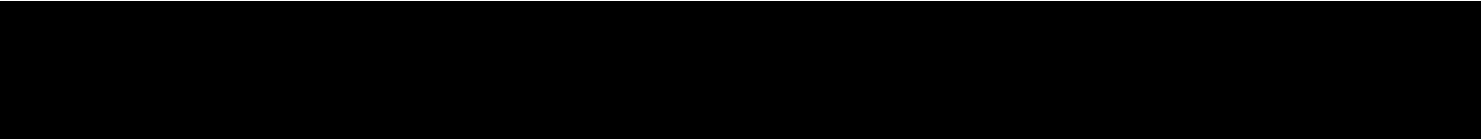
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/24/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/18/2009 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/30/2015 2. 02/08/2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/20/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2014 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2004 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/01/2015	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (number and street, city, state, and zip code) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/06/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/06/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/23/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 09/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 1			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2014 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/16/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/16/2016		Education Unknown	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/16/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 2009 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

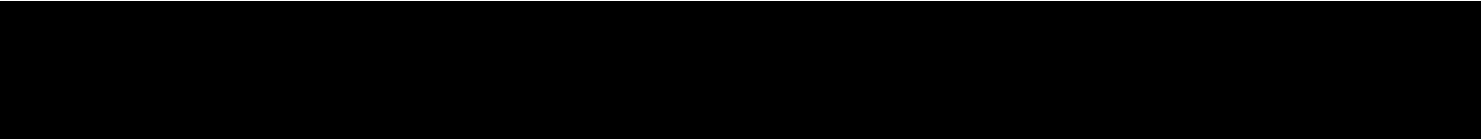
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1994 2. 2014 3. 2014 4. 2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

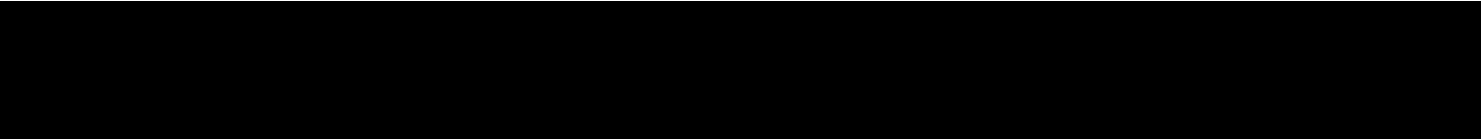
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 2014 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Bachelor's Degree		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 4		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 2		Number of induced terminations 3		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2014 3. 2013 4. UNKNOWN 5. UNKNOWN 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/29/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2004 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2014 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 2012 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/26/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/29/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

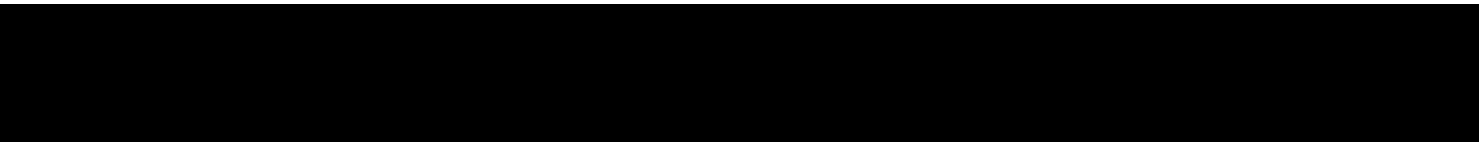
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/25/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2013 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/30/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/25/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 13	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/25/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/19/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 2			Number of induced terminations 3		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/10/2015	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (number and street, city, state, and zip code) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/19/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/12/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 2
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/12/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2015 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 15		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/12/2016		Education 8th Grade or Less	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/14/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/13/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/05/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/23/2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 10/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 01/05/2016		Education Doctorate/Professional Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/04/2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2014 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 10/17/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/04/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/04/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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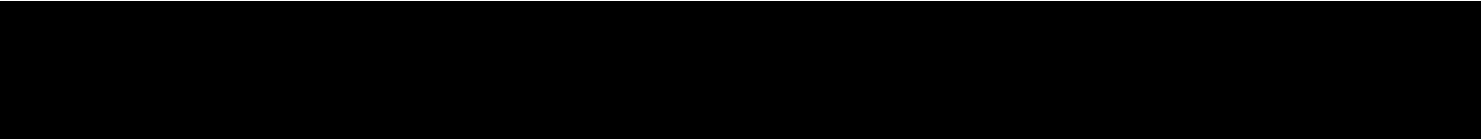
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/04/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/04/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
--	--	--	--	--	--

Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/04/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/11/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

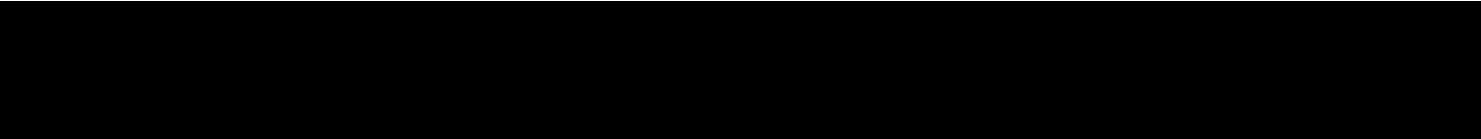
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 01/16/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
CHORIONIC VILLAE, GESTATIONAL SAC		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
CHORIONIC VILLAE, GESTATIONAL SAC		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 2011 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/04/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2008	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2009 3. 2010 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/18/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 02/27/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2008 3. 2010 4. 2013 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. MARTIN HASKELL
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N. ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/08/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/04/2016		Education Master's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: POC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/01/2015	Physician estimate of gestation (in weeks) 13	Post fertilization age of the fetus (in weeks) 11
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (number and street, city, state, and zip code) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 02/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 09/30/2015	Physician estimate of gestation (<i>in weeks</i>) 19	Post fertilization age of the fetus (<i>in weeks</i>) 17
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 09/19/2015	Physician estimate of gestation (<i>in weeks</i>) 21	Post fertilization age of the fetus (<i>in weeks</i>) 19
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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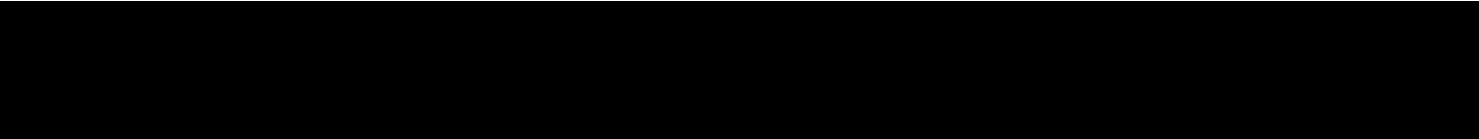
Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input checked="" type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2012 3. 2014 4. 2015 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2015 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/12/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATIO, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

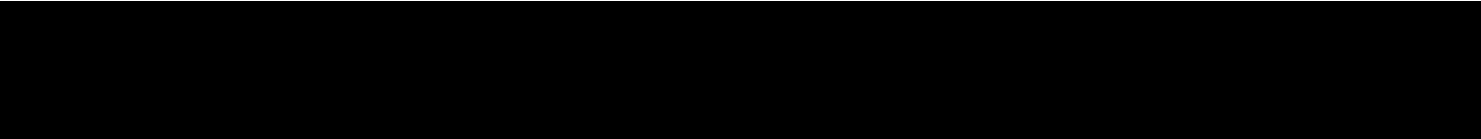
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 1999 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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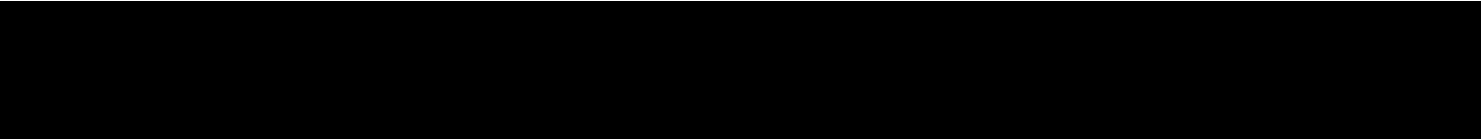
Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 10/08/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2010	2. 2013	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2001	2. 2010	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/22/2013 2. 12/06/2013 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. 10/2013	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1992 2. 1999 3. 2010 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMNATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

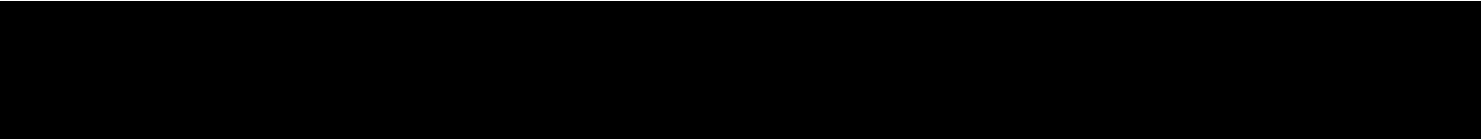
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 2011 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2002 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2011	2. 2010	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 1
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 02/06/2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/06/2015	Physician estimate of gestation (<i>in weeks</i>) 19	Post fertilization age of the fetus (<i>in weeks</i>) 17
How were the gestational age and post fertilization age determined? LMP		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/18/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: POC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>D&E</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2001 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2008 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 8	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2002 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/26/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1997 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/10/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 02/06/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

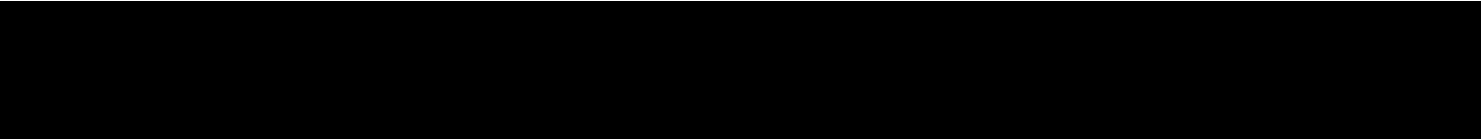
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/26/2016		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 03/20/2015 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 03/08/2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1999 2. 10/2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. UNKNOWN 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2008 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 10/08/2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/10/2014 2. 04/02/2015 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/22/2009 2. 09/16/2011 3. 03/20/2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma		
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/03/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 6	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

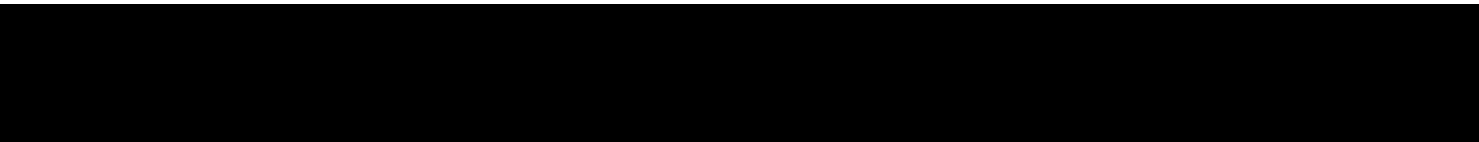
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2001 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2009 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/06/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 2			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLI, FETAL PARTS					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2013 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2009 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

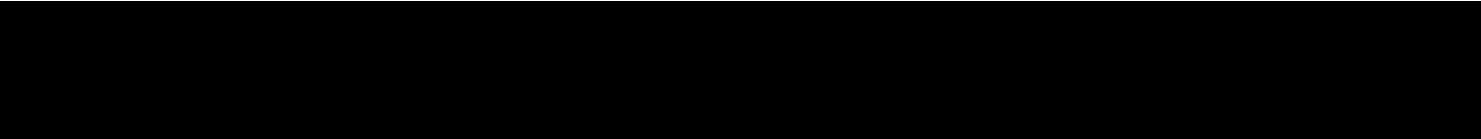
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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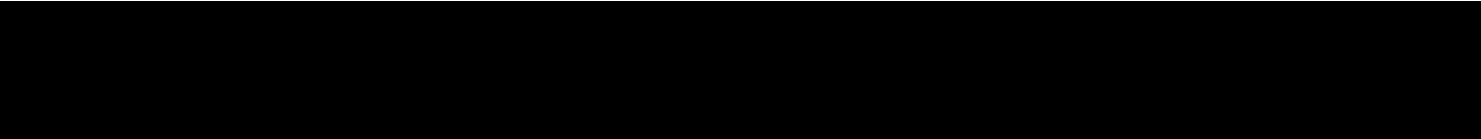
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/06/2013 2. 02/15/2014 3. 07/24/2015 4. 02/27/2010 5. UNKNOWN 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/14/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

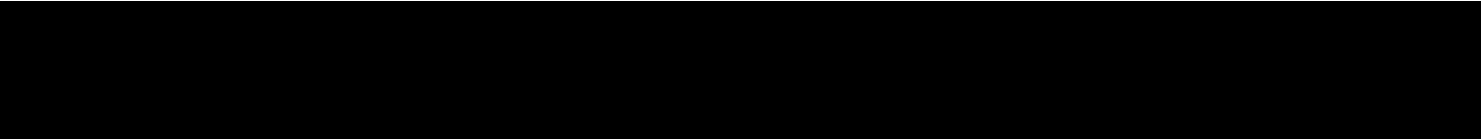
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/02/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/02/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/02/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2012 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/02/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2014 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshtlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/05/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/26/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: SAC AND CHORIONIC VILLI			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRAOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/12/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/12/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 2	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/13/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2013 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/13/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2012 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2009 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/19/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013 2. 2013 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2012 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/18/2014 2. 02/16/2013 3. 09/26/2012 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 4	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/30/2011 2. 02/24/2012 3. 2013 4. 2009 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2004 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/23/2003 2. 04/22/2005 3. 07/22/2011 4. UNKNOWN 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

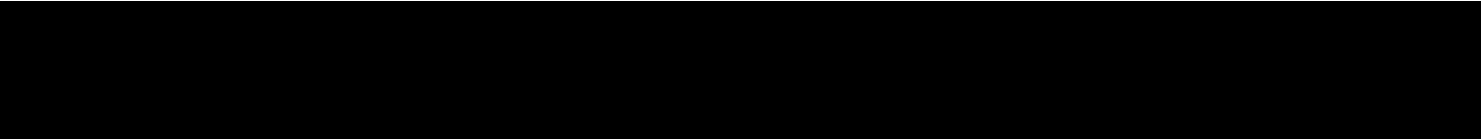
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2013 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/2013 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2013 3. 2014 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/23/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2006 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2004 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/22/2016		Education Master's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/22/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/22/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2011 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/22/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/16/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 8	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1997 2. 2010 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

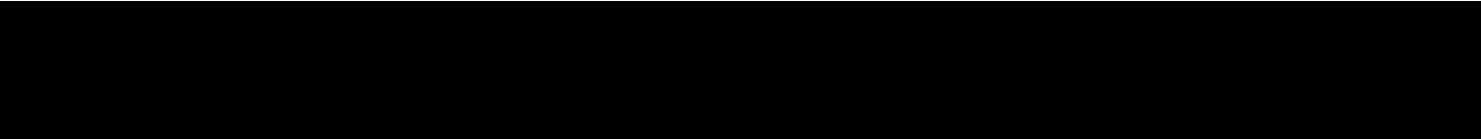
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2014 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/15/2016		Education Unknown	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/15/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 4		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/15/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2012 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2006 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/09/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2011 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2015 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/09/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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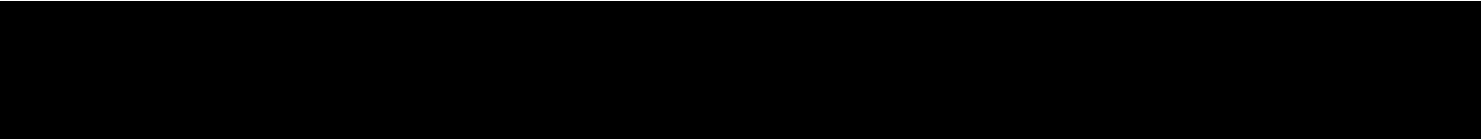
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/15/2004 2. 11/12/2004 3. 01/09/2010 4. 05/30/2014 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI,	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

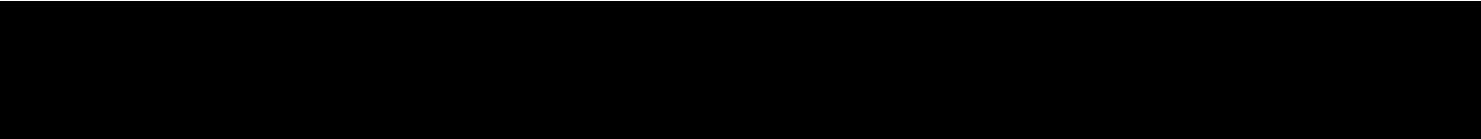
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2005 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/24/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1993 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2003 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 02/05/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 02/26/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma		
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2014 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

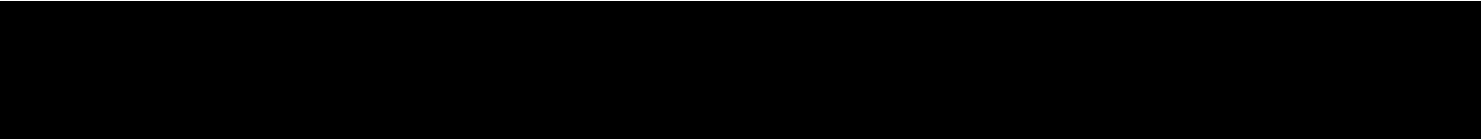
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. 08/15/2014	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/14/2016 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/13/2013 2. 06/12/2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/07/2015 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 09/27/2011 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2003 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/17/2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/07/2010 2. 07/18/2013 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2004	2. 2006	3. 2007	4. 2010	5. 2013	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2004 3. 2009 4. 2015 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/14/2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/19/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2012 3. 08/28/2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 01/22/2009 3. 07/11/2014 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2009 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

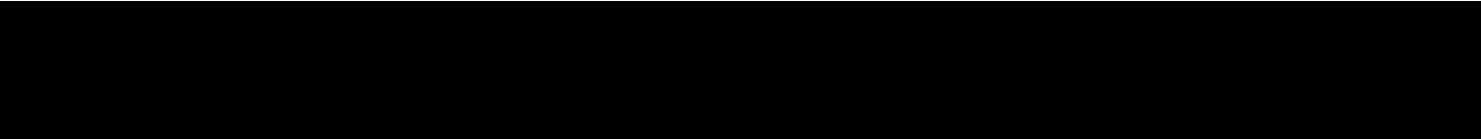
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/11/2016		Education Master's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2012 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. 04/17/2014	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

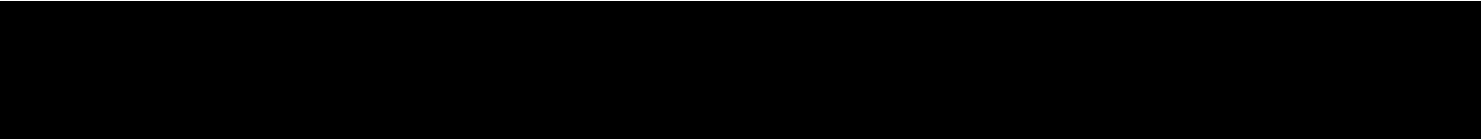
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input checked="" type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input checked="" type="checkbox"/> Other (<i>Specify</i>) SEPSIS Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/29/2015	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

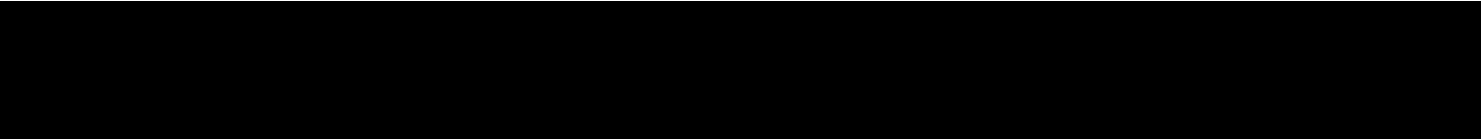
Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 2		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (number and street, city, state, and zip code) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 03/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input checked="" type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

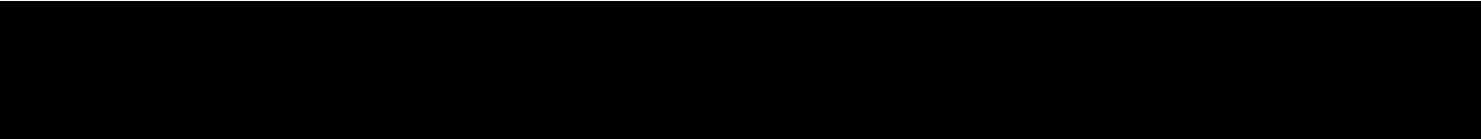
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 2013 3. 2015 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2005 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2009 3. 08/14/2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/06/2013 2. 12/19/2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2002 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2016 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

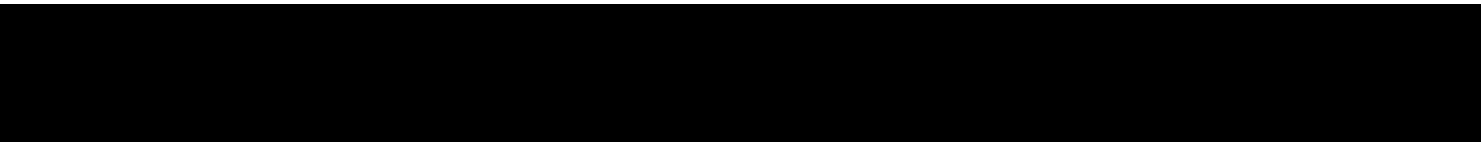
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2004 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

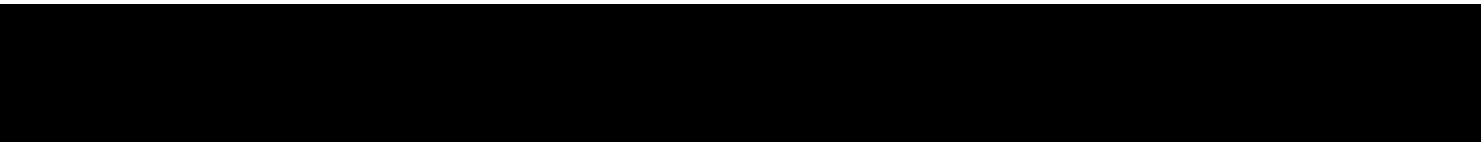
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1994 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/22/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION,

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/24/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/27/2008 2. 05/01/2015 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 01/08/2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2010 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2004 3. 2005 4. 2005 5. 2008 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 11/27/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2013 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/24/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/16/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Master's Degree
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Master's Degree
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2011 4. 08/2015 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 17	Post fertilization age of the fetus (<i>in weeks</i>) 15
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED		
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/16/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2001 2. 2008 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/16/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/16/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/02/2016		Education 9th-12th, No Diploma	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/02/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

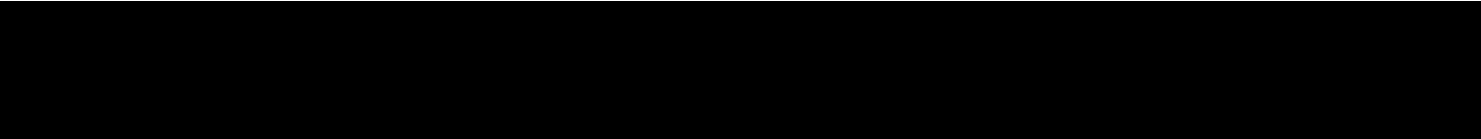
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/02/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 03/16/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2004 3. 2015 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 03/04/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2005 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/05/2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/04/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/11/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 4			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 2			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/11/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/11/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 03/11/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/11/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/12/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1996 2. 1999 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2010 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/12/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

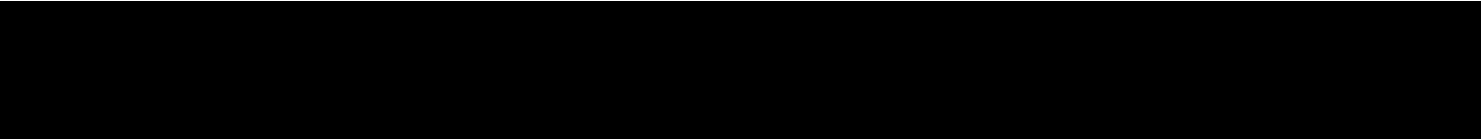
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2005 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/18/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/18/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/18/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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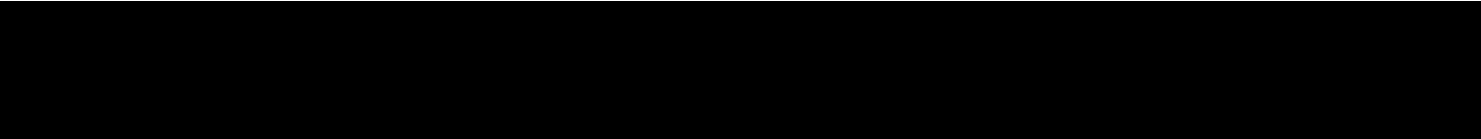
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

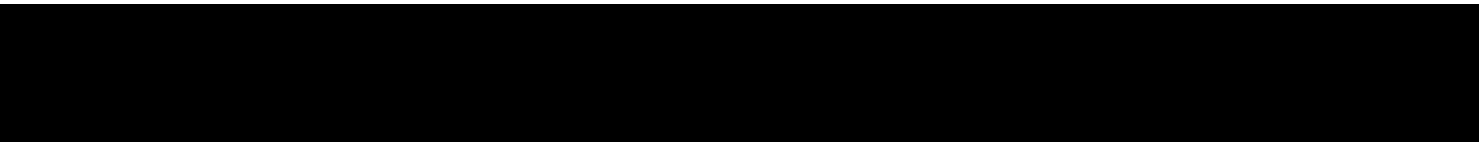
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 46	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/25/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/25/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2013 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

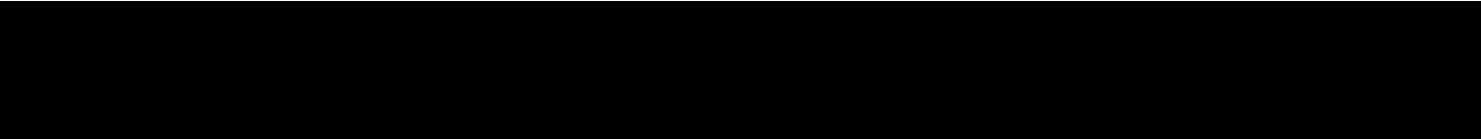
Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/25/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 16		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/25/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/25/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/26/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

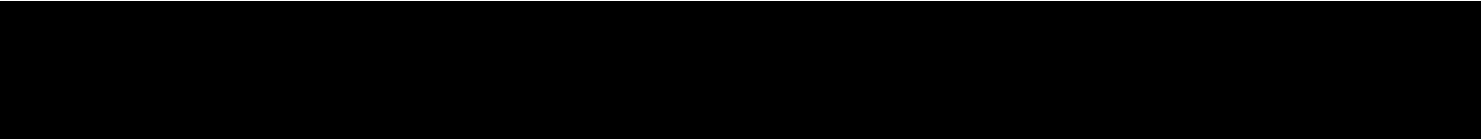
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORONIC VILLI,AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VLLLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2011 3. 2010 4. 2009 5. 2009 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

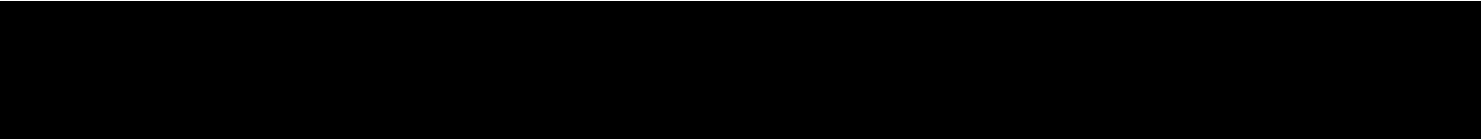
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AN FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2003 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHRIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

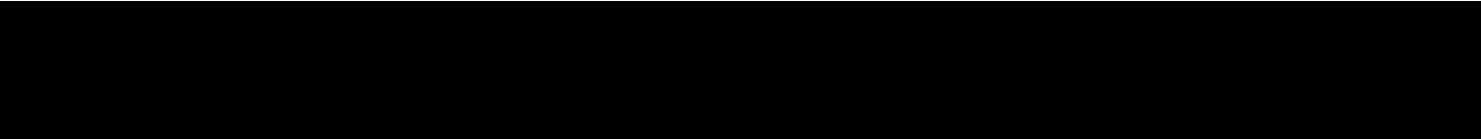
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 03/30/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/30/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/30/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2015	2. 2014	3. 1999	4. 2001	5. UNKNOWN	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/30/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2013 2. 2010 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 2	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2010 3. 2009 4. 2003 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/20/2014 2. 10/27/2012 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/17/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 08/28/2015 2. 02/22/2013 3. 11/12/2011 4. 08/10/2007 5. 12/22/2006 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (number and street, city, state, and zip code) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/2015 2. 05/15/2015 3. 03/20/2009 4. 2014 5. 2008 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					

Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 2015 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

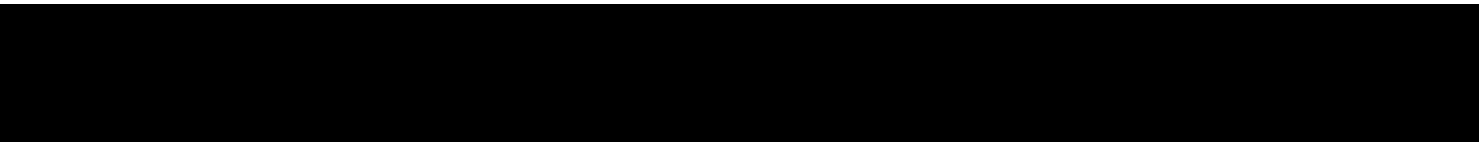
Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

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**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/15/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 01/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/14/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 4		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 2
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/14/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/01/2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:	Number now living 3	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (in weeks) 13	Post fertilization age of the fetus (in weeks) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (number and street, city, state, and zip code) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 0		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/07/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/07/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/07/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <p>_____</p> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <p>_____</p> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <p>_____</p> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <p>_____</p> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/07/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/07/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1999 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/01/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 03/01/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2011 3. 2013 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/04/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/30/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. UNKNOWN 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/16/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

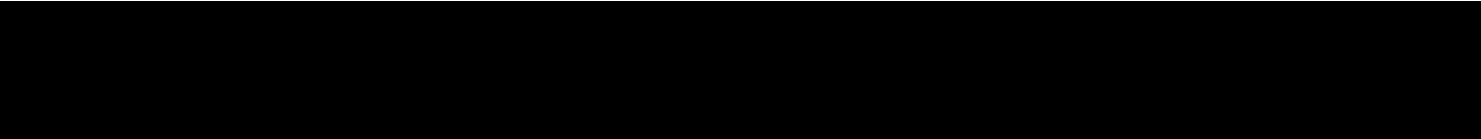
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/26/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 03/26/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/26/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 12/05/2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2007 3. 2012 4. 02/27/2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2010 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Master's Degree
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2006 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

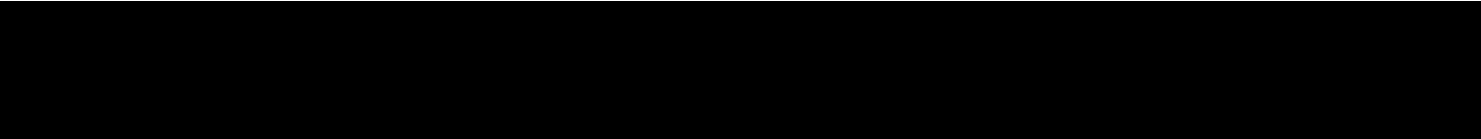
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2010 4. 2014 5. _____ 6. _____	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/08/2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATIONS

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2011 3. 2012 4. 2012 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2007 3. 2009 4. 2014 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 12/03/2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION,

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/08/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 02/27/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2012 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2001	2. 2008	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 1993 3. 2001 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 45	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2012 3. 2013 4. 2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2014 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 08/29/2012 3. 2013 4. 07/11/2014 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION,

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/21/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1999 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014	2. 2015	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 5		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2008 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC ECAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. UNKNOWN 3. UNKNOWN 4. 5. 6.

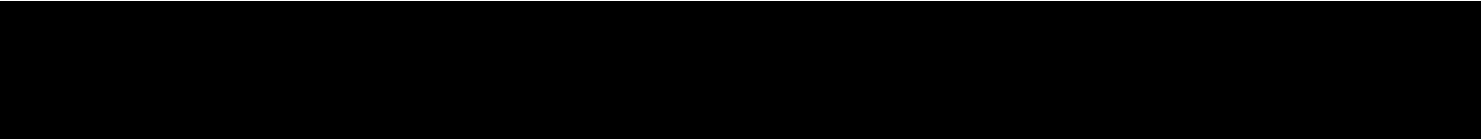
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2014 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

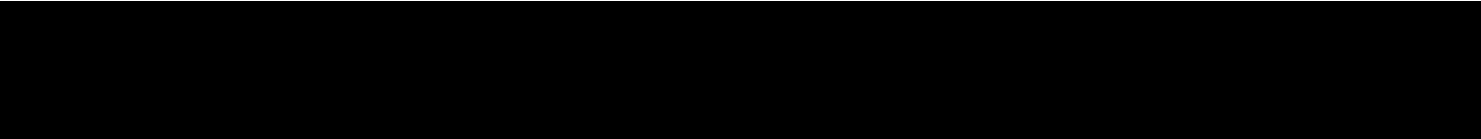
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2012 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

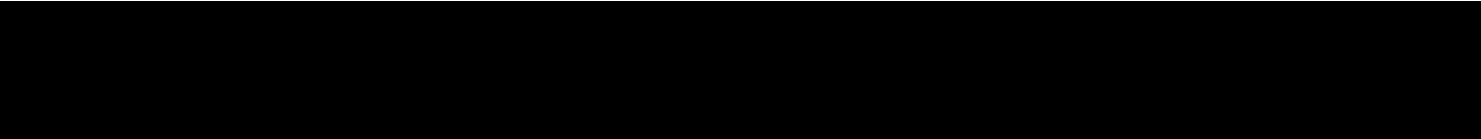
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 0
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 10/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/28/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2007 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 04/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 6	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>D&E</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/01/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>D&E</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 19	Post fertilization age of the fetus (<i>in weeks</i>) 17
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 2
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2010 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/30/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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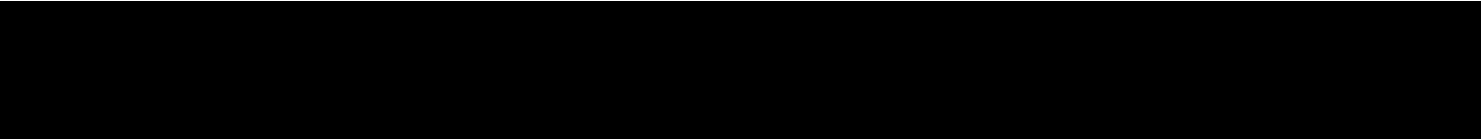
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/26/2014 2. 2013 3. 2009 4. UNKNOWN 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORINIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2006 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2010 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other					
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

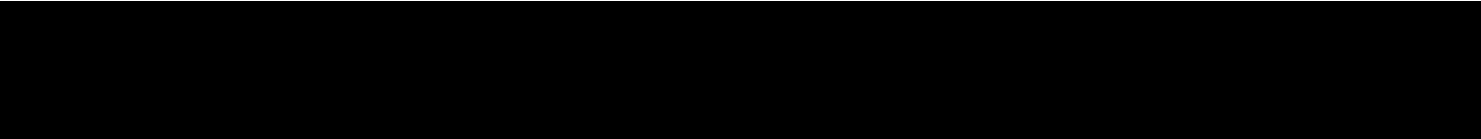
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/2016 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/23/2012 2. 09/20/2007 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 11/14/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

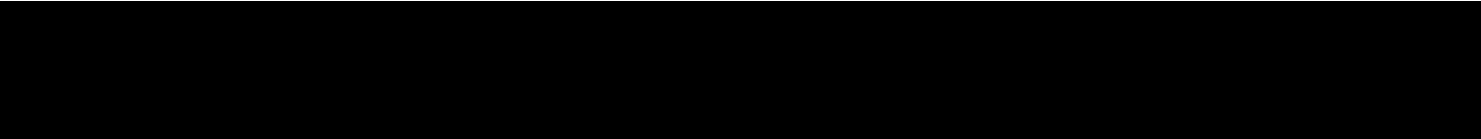
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/24/2015 2. 03/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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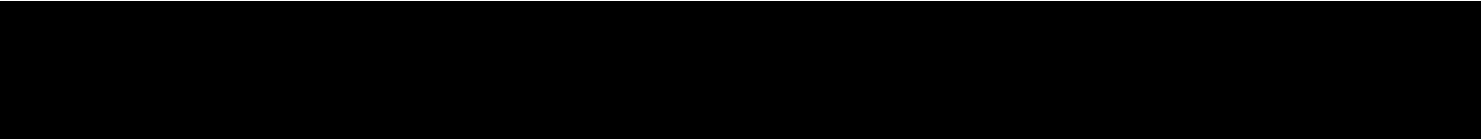
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 07/17/2015 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1996 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2009 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/13/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/13/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/13/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/25/2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2007 3. 4. 5. 6.		
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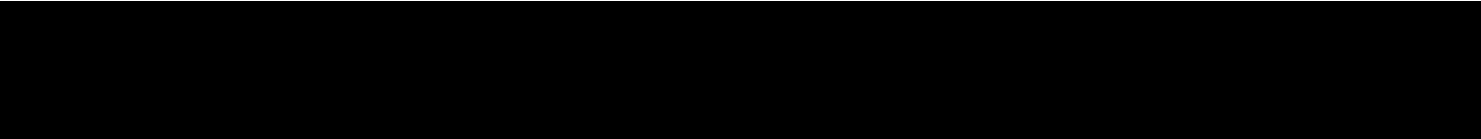
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/22/2015 2. 09/20/2014 3. 10/27/2012 4. 01/27/2012 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC AND VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

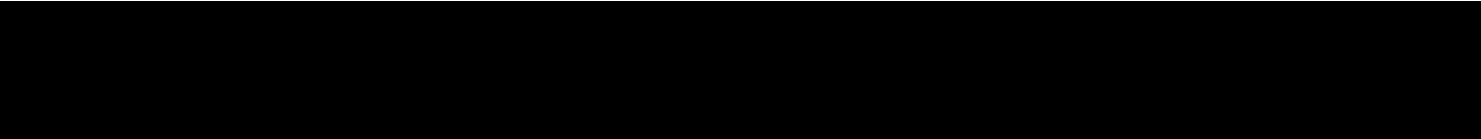
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 7	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RESAD PASIC
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 2411 NEWBURG RD, LOUISVILLE, KY 40205



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 2			

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 1994 2. 1997 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/28/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other					
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2			

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/26/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/22/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/22/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/22/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/01/2016 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

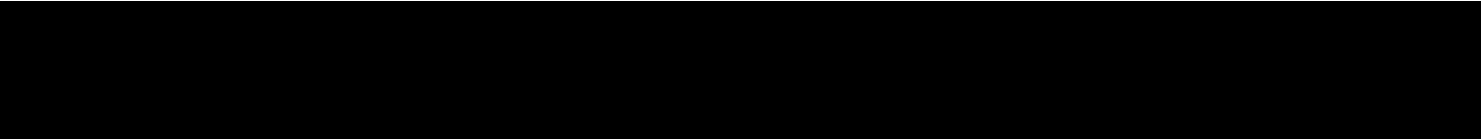
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/15/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/15/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/15/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2009 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

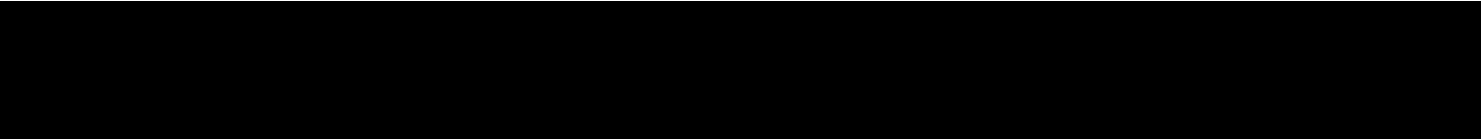
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. UNKNOWN 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

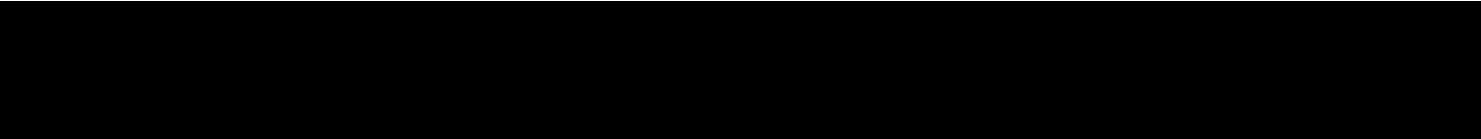
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 44		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 2			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/08/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/2013 2. 11/2013 3. 07/2014 4. 02/2015 5. 11/2015 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. UNKNOWN 3. UNKNOWN 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 10	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/29/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/29/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/29/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2011 3. 2015 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

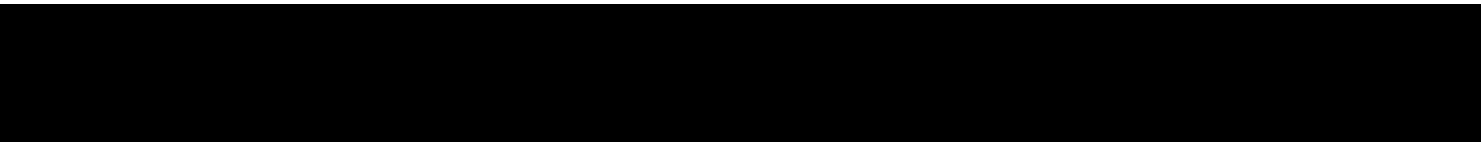
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/22/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/22/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/15/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/15/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/27/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
---	--	--	--	--	--

Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 3	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/27/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 18		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/27/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2013 3. 2014 4. UNKNOWN 5. UNKNOWN 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRAASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/27/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

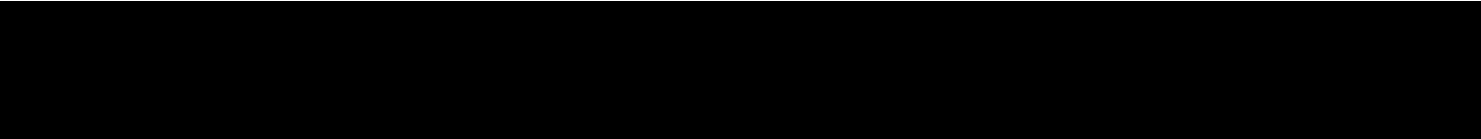
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016		Education	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living		Number now deceased		
Other Terminations:	Number of spontaneous terminations		Number of induced terminations		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/18/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown				Ethnicity			
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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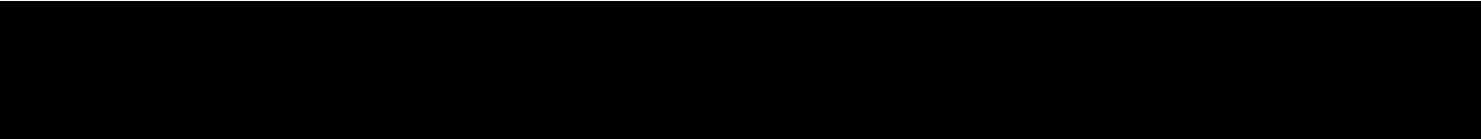
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
-------------------------------	---	---

How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/26/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

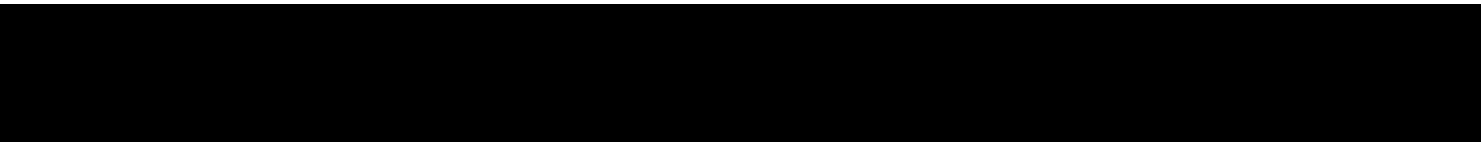
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/25/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/25/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

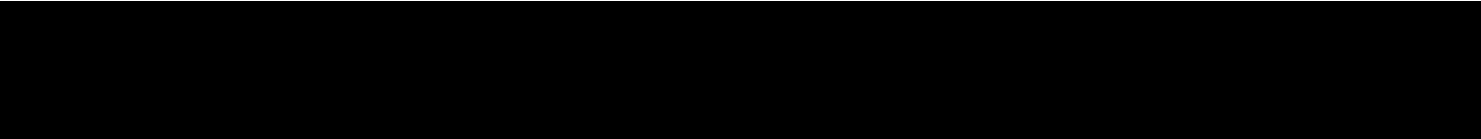
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 9	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/19/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/19/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/19/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/19/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

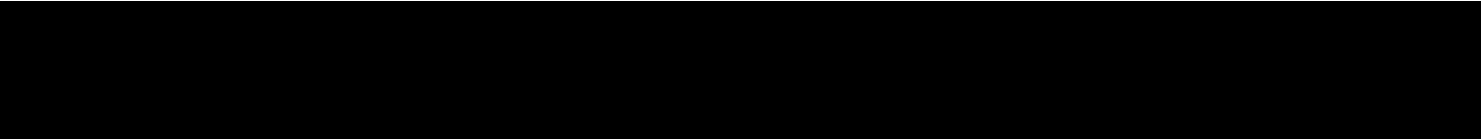
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2005 3. 2009 4. 2009 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/18/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

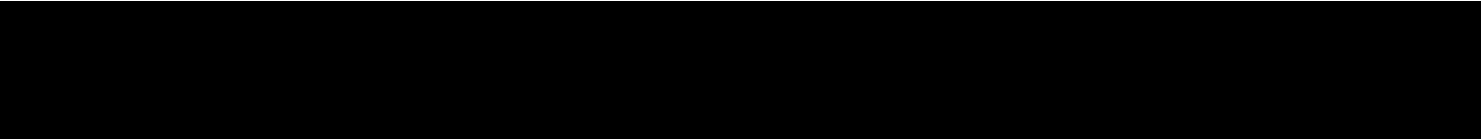
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/12/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 46	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 46	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education Doctorate/Professional Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 2		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/05/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education Master's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/05/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
--	--	--	--	--	--

Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2013 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/04/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/04/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/31/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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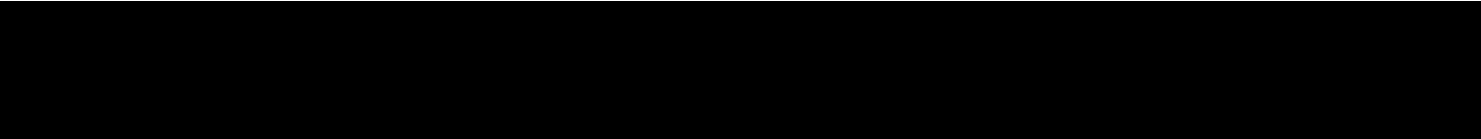
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2011 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 46		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/11/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/19/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/01/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/04/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 04/13/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/18/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 04/19/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINIATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2008 3. 2011 4. UNKNOWN 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1998 2. 2011 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1994 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2003 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education Master's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2011 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 12/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 08/23/2013 4. 03/13/2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/12/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAN AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2013 3. 2008 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 2012 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

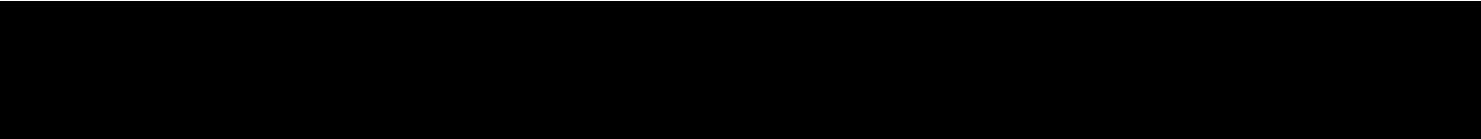
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 5	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 2014 5. 2015 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

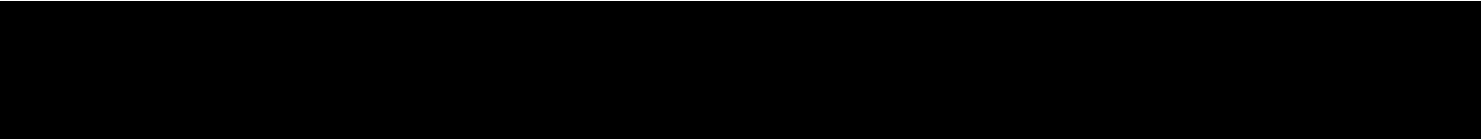
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 04/11/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 6

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. 2009	6. 2014

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, & FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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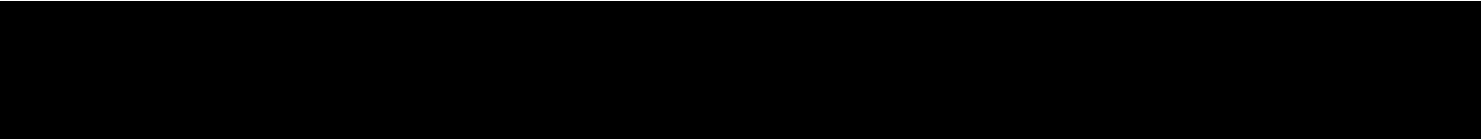
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

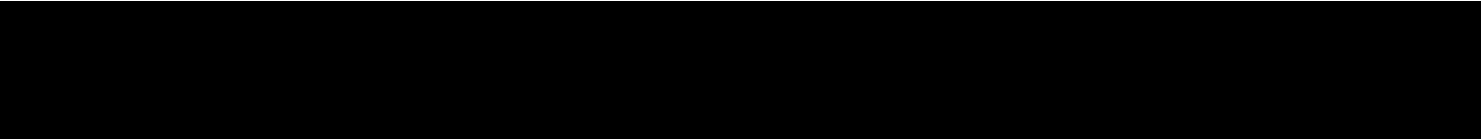
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 12/13/2013 3. 02/02/2013 4. 09/11/2008 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

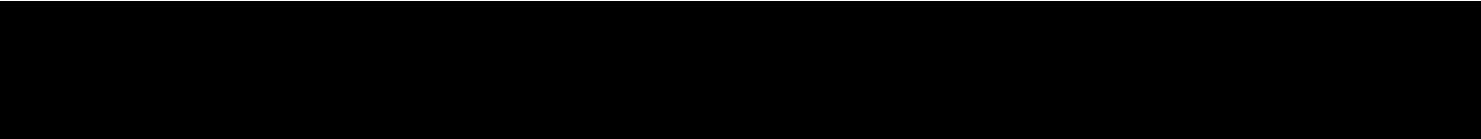
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2016	2. 2016	3. 12/04/2015	4. 06/04/2015	5. 2012	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/22/2016 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/14/2015 2. 07/17/2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2007 3. 2009 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/07/2016	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2011 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/18/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 07/09/2011 2. UNKNOWN 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2009 3. UNKNOWN 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2009 3. 01/08/2016 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 0
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/20/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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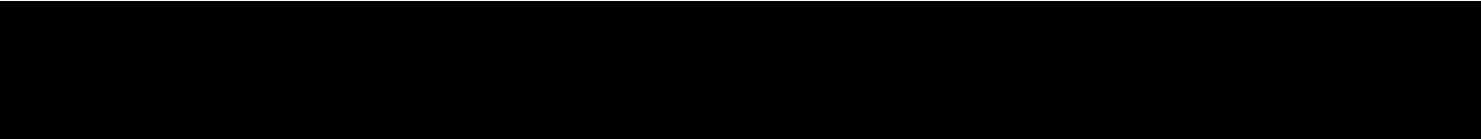
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

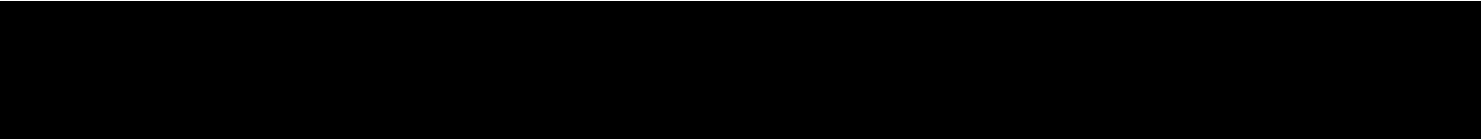
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 1	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/21/2015 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

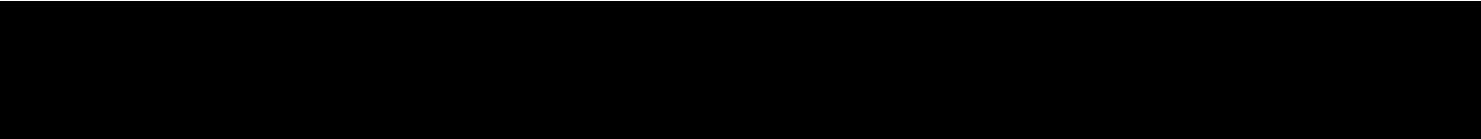
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/13/2002 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2014 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

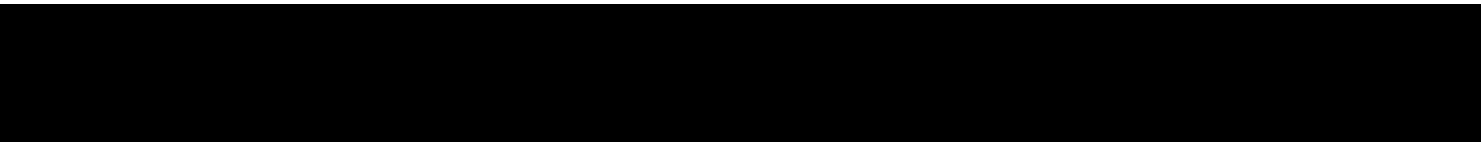
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHRONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

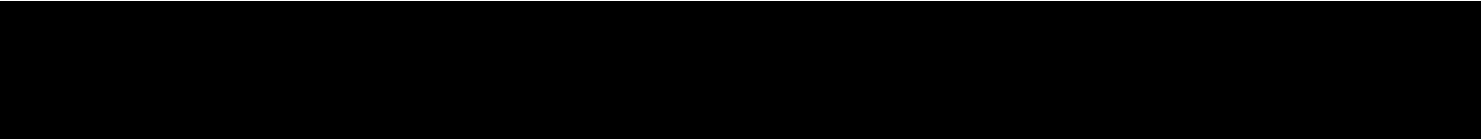
Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINTION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2011 3. 2013 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

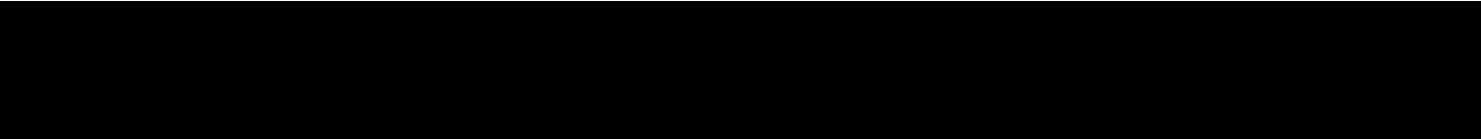
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1996 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/26/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1996 2. 2013 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/2002 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

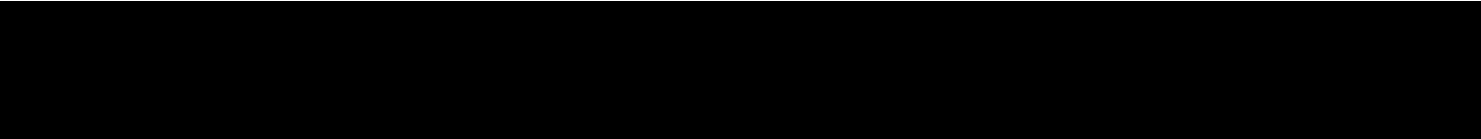
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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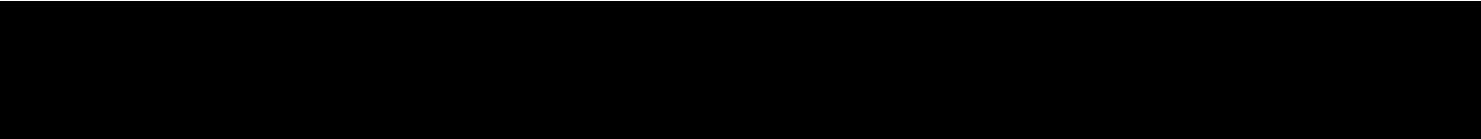
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/30/2013 2. 01/14/2012 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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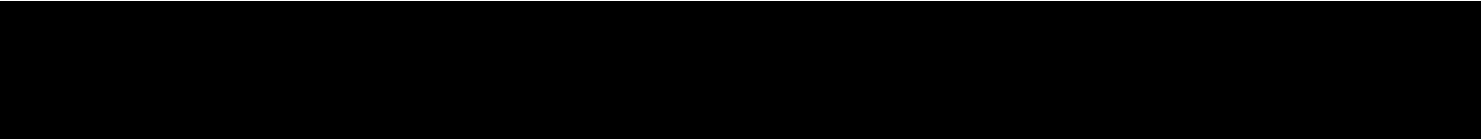
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input checked="" type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 0	Post fertilization age of the fetus (<i>in weeks</i>) 0
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 4	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2005 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 5		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/02/2013	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 16	Post fertilization age of the fetus (<i>in weeks</i>) 14
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 15	Post fertilization age of the fetus (<i>in weeks</i>) 13
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How were the gestational age and post fertilization age determined? LMP
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Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 21	Post fertilization age of the fetus (<i>in weeks</i>) 19
How were the gestational age and post fertilization age determined? LMP		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 14	Post fertilization age of the fetus (<i>in weeks</i>) 12
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How were the gestational age and post fertilization age determined?
LMP

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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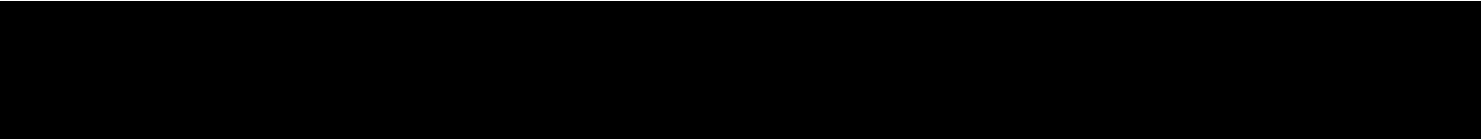
Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2015 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/27/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 2
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/26/2013 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/27/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/2016 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education Unknown
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 3	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0			

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/27/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/20/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2014 3. 2015 4. 2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/20/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUNDS		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2013 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

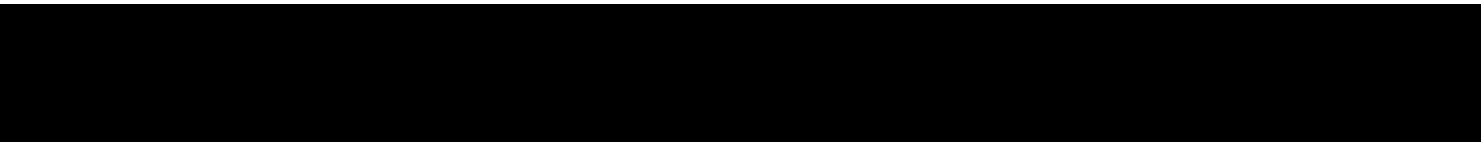
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2015 3. 2016 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

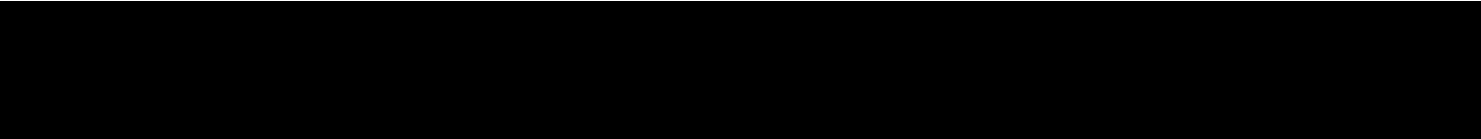
Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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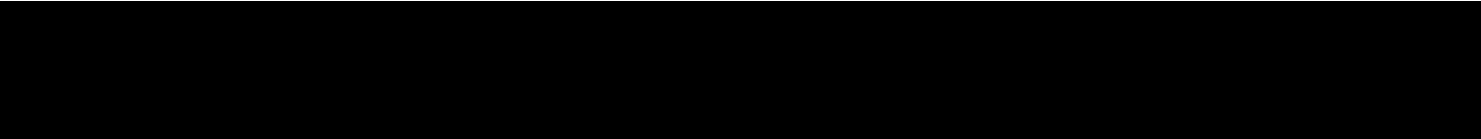
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/07/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/07/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/07/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 41		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 43		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/06/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1997 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input checked="" type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/25/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

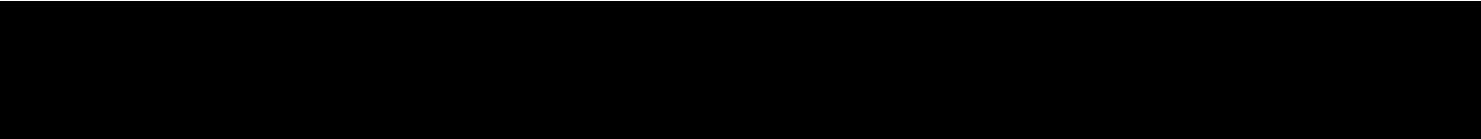
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/25/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/25/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/25/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/11/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 16		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/11/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2011 3. 2012 4. 2016 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

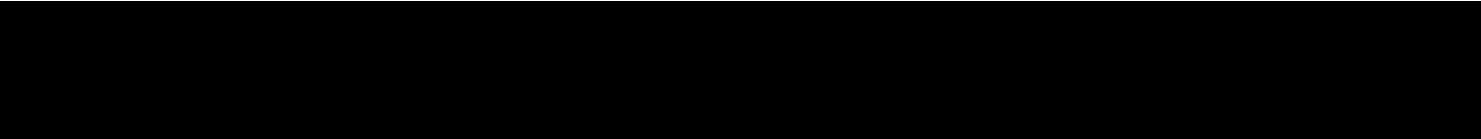
Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/11/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/11/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2003 4. 2006 5. 2010 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. 2015	3. UNKNOWN	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/31/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/31/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/31/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Unknown		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2015	2. 2007	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Bachelor's Degree
Race <input checked="" type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/31/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1995 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/31/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living 2		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/31/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/24/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/23/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 3		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2015 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

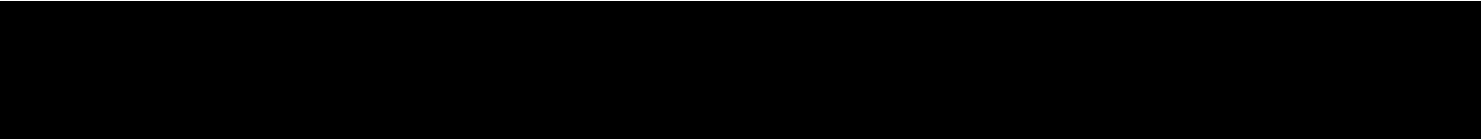
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2011 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/22/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012 2. UNKNOWN 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/23/2016		Education	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:	Number now living		Number now deceased		
Other Terminations:	Number of spontaneous terminations		Number of induced terminations		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/23/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/17/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2014 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/17/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/16/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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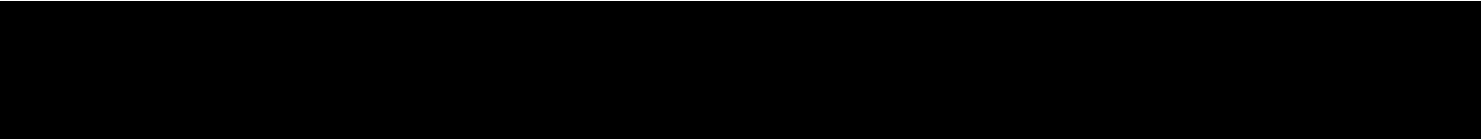
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/16/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/13/2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/10/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/09/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2001 3. 2015 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1999 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2016 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/03/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/03/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 07/29/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 1997 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2012 3. 2011 4. 2014 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

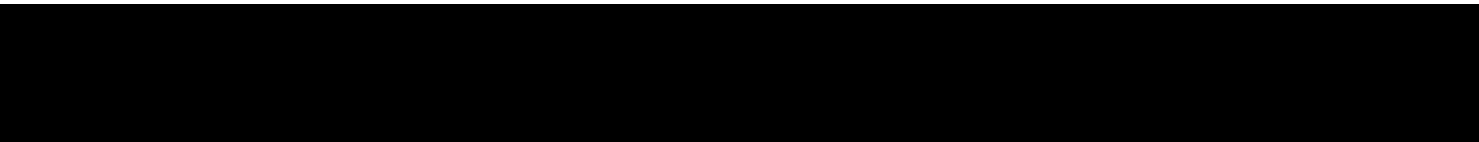
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

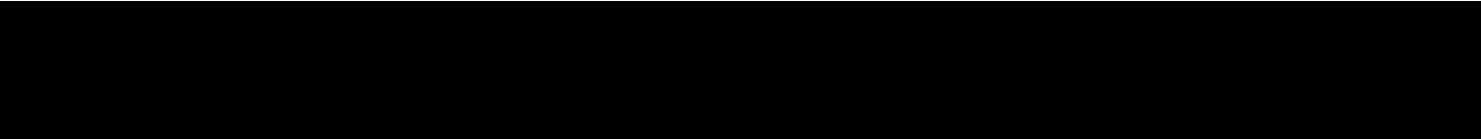
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/03/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2008 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 05/02/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2014 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/02/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
--	--	--	--	--	--

Live Births:	Number now living 1	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 1	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/09/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/16/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity			
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/17/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 05/13/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/20/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 2004 3. 2009 4. UNKNOWN 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2015 3. 2016 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
		CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education 9th-12th, No Diploma
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 3

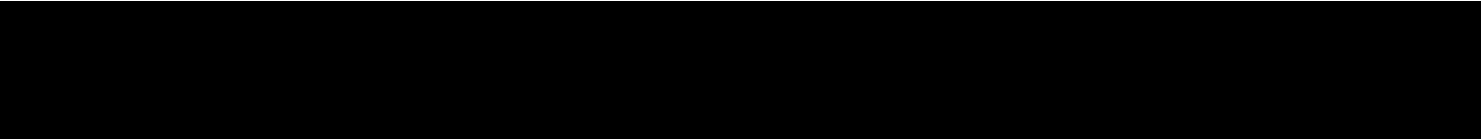
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 1992	2. 1994	3. 1996	4. 1998	5. 2013	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/02/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 5

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2006	2. 2008	3. 2009	4. 2010	5. 2012	6. 2013

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 5	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

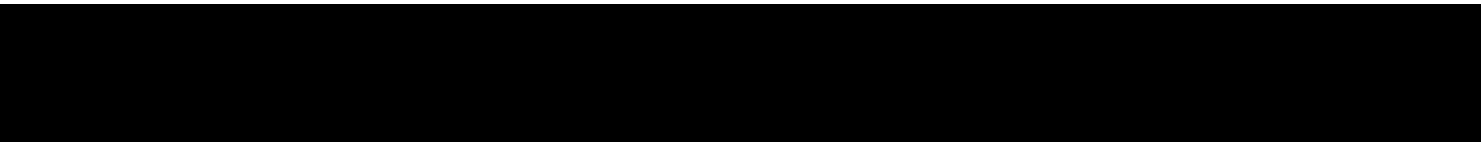
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

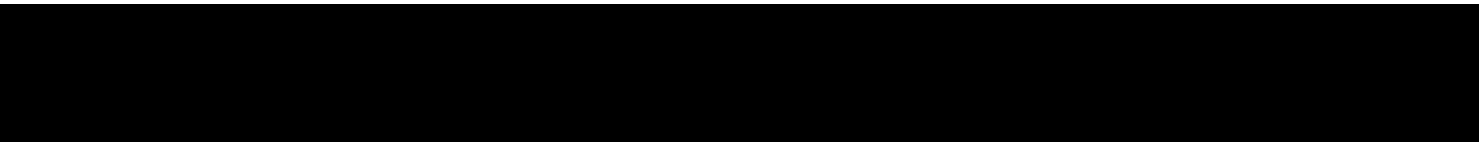
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2004 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 03/18/2016 3. 2014 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

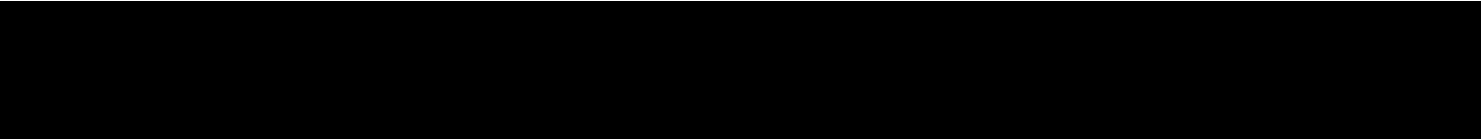
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2013	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

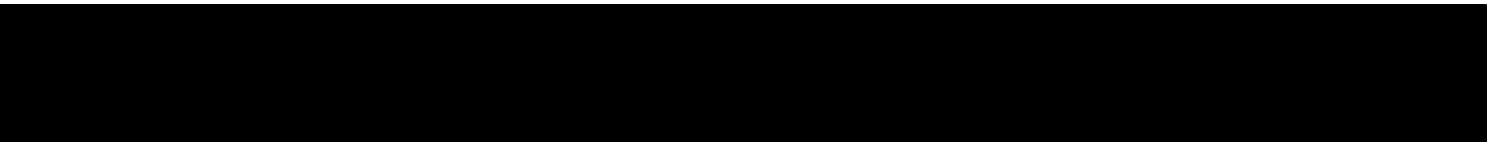
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/16/2016 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

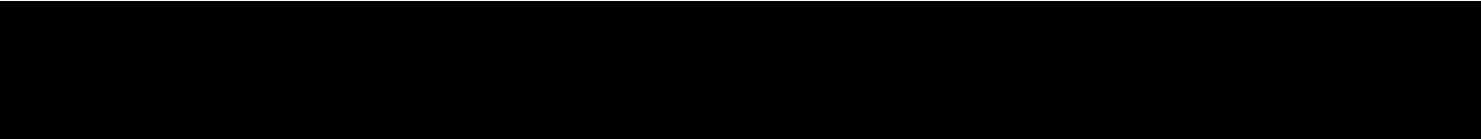
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/11/2016		Education High School Diploma or GED	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 2			Number of induced terminations 3		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/04/2014 2. 01/04/2014 3. 08/02/2013 4. UNKNOWN 5. UNKNOWN 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLI AND FETAL PARTS					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/12/2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

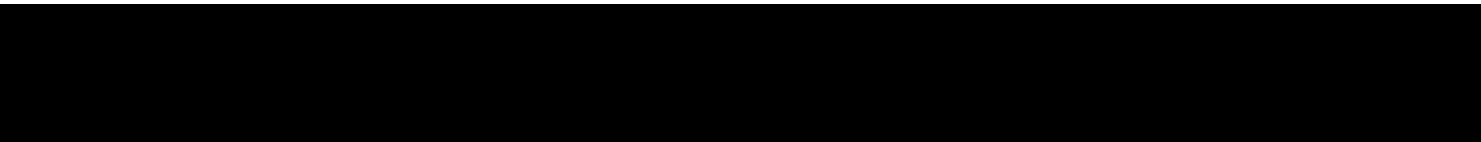
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/09/2016 2. 2015 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/05/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination RAYMOND E. ROBINSON
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET STE. 20, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

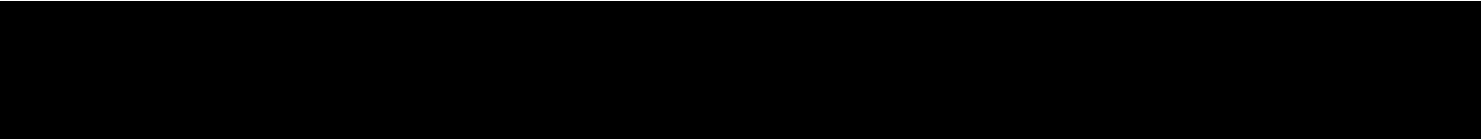
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2014 3. 2012 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

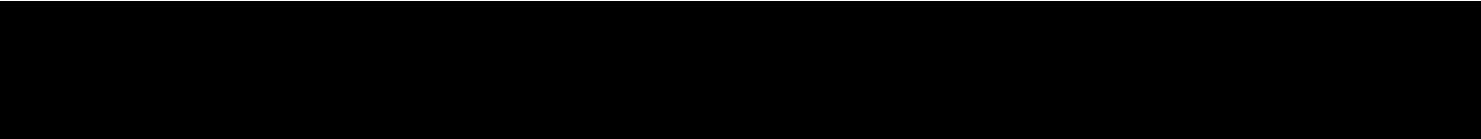
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 45	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Doctorate/Professional Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. 2014	6. 2015

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 09/12/2013 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1998 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2009 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 10/11/2013 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2011 3. 2000 4. 5. 6.		
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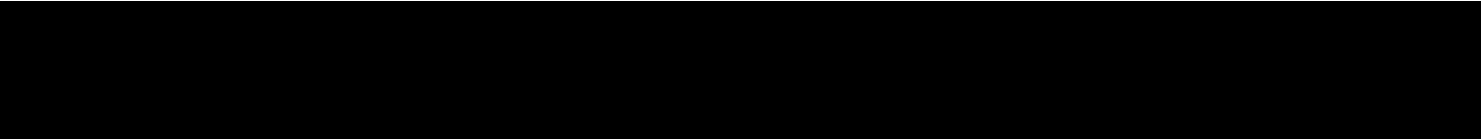
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/10/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/14/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 6

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 1998	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 08/14/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. 02/26/2016	3. UNKNOWN	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND FETAL PARTS	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 05/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. 2011	3. 1999	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 6

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2007 3. 2005 4. 2004 5. 2002 6. 2001					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI AND FETAL PARTS	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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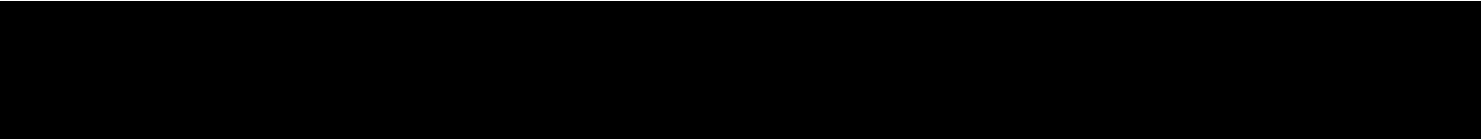
Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILII		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2011 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination WALTER T BOWERS
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 10TH STREET SUITE 2B, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 6

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input checked="" type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) <hr/> Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI		

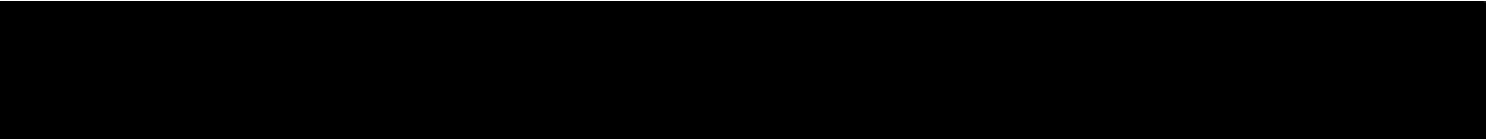
Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/12/2016	Physician estimate of gestation (in weeks) 0	Post fertilization age of the fetus (in weeks) 0
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/24/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 1	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLI AND SAC			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone</div> <div><input type="checkbox"/> Medical (Nonsurgical) Misoprostol</div> <div><input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage</div> <div><input type="checkbox"/> Medical (Surgical) Menstrual Aspiration</div> <div><input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone</div> <div><input type="checkbox"/> Medical (Nonsurgical) Misoprostol</div> <div><input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage</div> <div><input type="checkbox"/> Medical (Surgical) Menstrual Aspiration</div> <div><input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Master's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 7	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/1998 2. 01/01/1997 3. 01/01/2004 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/13/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2008 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 46	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 7

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2007	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/24/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Master's Degree
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/12/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

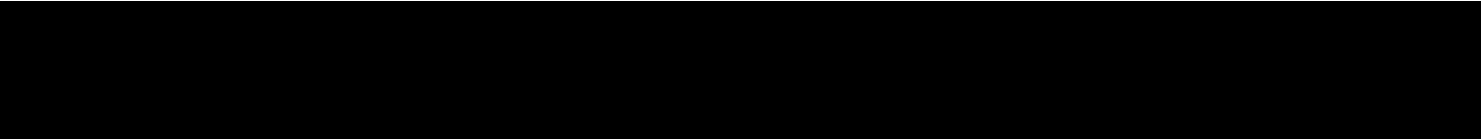
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 07/03/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION, PELVIC EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND EXAMINATION		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

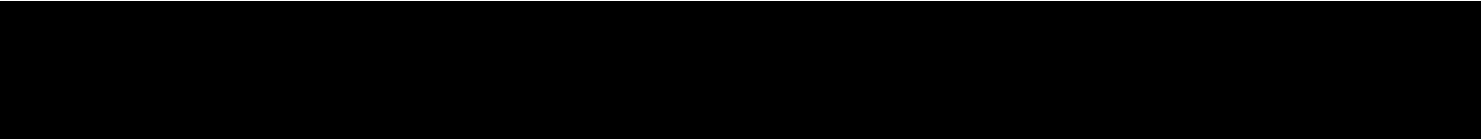
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
SONOGRAM

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: CHORIONIC VILLI		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	
		Did this termination of pregnancy result in a maternal death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/03/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 30	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (number and street, city, state, and zip code) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 2		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/31/2015 2. 08/02/2014 3. 09/27/2013 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC, CHORIONIC VILLI, AND FETAL PARTS	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

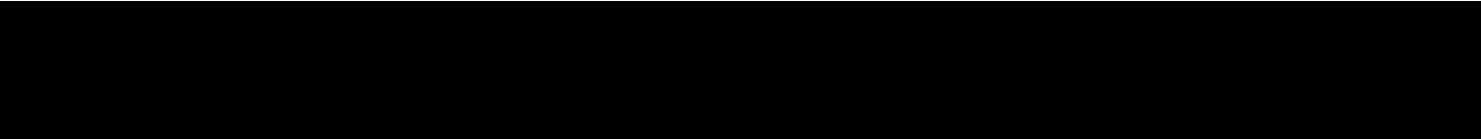
Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address CLINIC FOR WOMEN - 3607 WEST 16TH STREET SUITE B2, INDIANAPOLIS, IN 46222		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 3		Number of induced terminations 2		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 2000 5. 1995 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: SAC AND CHORIONIC VILLI				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? SONOGRAM		

Full name of physician performing termination KATHLEEN GLOVER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 3607 WEST 16TH STREET, INDIANAPOLIS, IN 46222



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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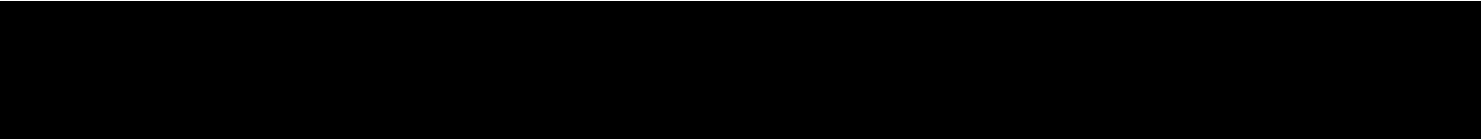
Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/23/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 6			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: POC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input checked="" type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>D&E</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
How were the gestational age and post fertilization age determined? LMP		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 18	Post fertilization age of the fetus (<i>in weeks</i>) 16
How were the gestational age and post fertilization age determined? US		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 38		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/07/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: POC					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 16	Post fertilization age of the fetus (<i>in weeks</i>) 14
How were the gestational age and post fertilization age determined? LMP		

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/05/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address SIDNEY & LOIS ESKENAZI HOSPITAL - 720 ESKENAZI AVE, INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 14	Post fertilization age of the fetus (<i>in weeks</i>) 12
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How were the gestational age and post fertilization age determined? US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 15	Post fertilization age of the fetus (<i>in weeks</i>) 13
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL - 1701 SENATE AVE., INDIANAPOLIS, IN, 46202		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input checked="" type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: POC	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input checked="" type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) D&E For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 20	Post fertilization age of the fetus (<i>in weeks</i>) 18
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How were the gestational age and post fertilization age determined?
US

Full name of physician performing termination DR. HUA MENG
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 720 ESKENAZI AVE. F3, INDIANAPOLIS, IN 46202



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/06/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Unknown		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/03/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

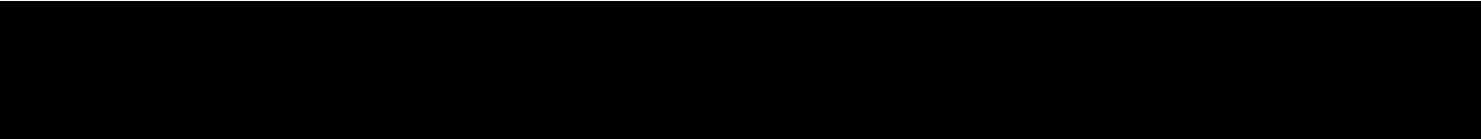
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/10/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRSAOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/10/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/13/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/14/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

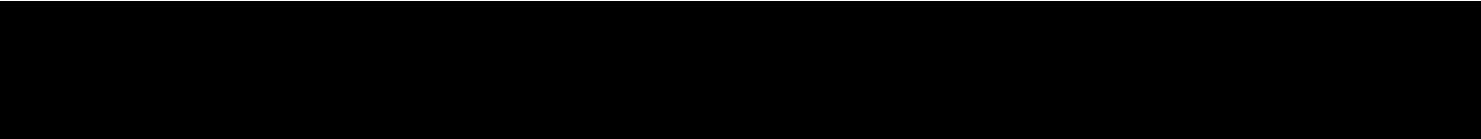
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/14/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/14/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/23/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity			
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 1996 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014 2. 2015 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/24/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 05/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 05/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/24/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshtlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/24/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2016 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2010 3. 4. 5. 6.					
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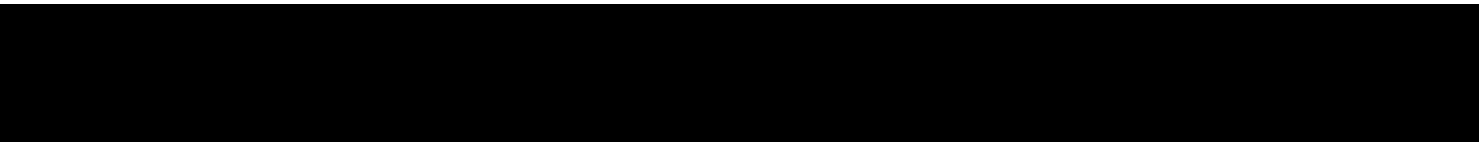
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2012 3. 2007 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:	Number now living 1		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/30/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 3	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/27/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 2		Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/27/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2014 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/27/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Doctorate/Professional Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/20/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/27/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2016 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 45		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/22/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 6		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Unknown
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/22/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White		<input type="checkbox"/> Black or African American <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:		Number now living 3		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2009 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

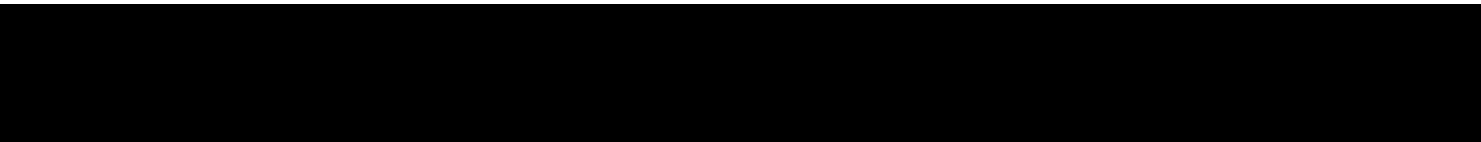
Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/22/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 1			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/20/2012	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/11/2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2013 3. 2014 4. 2015 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/22/2016		Education Doctorate/Professional Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 2			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/20/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 1			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/20/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2008 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 5	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/07/2015 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 05/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 41		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/20/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 3			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 0		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/20/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Live Births:		Number now living 0			Number now deceased 0		
Other Terminations:		Number of spontaneous terminations 0			Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:			Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRSAOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. 2012 3. 2006 4. 2004 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/20/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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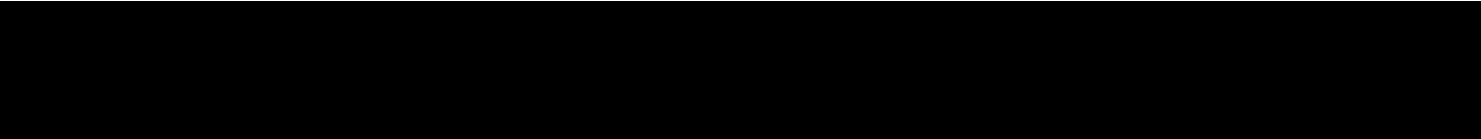
Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/08/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2013 3. 2013 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/08/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 1	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/10/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/08/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 3	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2014 3. 2014 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? UTLRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Doctorate/Professional Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2011 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? UTLRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/03/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2005 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/03/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 2	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/03/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 3		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Bachelor's Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 2	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1			

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2012 3. 2014 4. 2015 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2004 3. 2016 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education 9th-12th, No Diploma		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity			
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/10/2016		Education 9th-12th, No Diploma	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
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Live Births:	Number now living 0	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016		Education Associate Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		<input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3		Number now deceased 0		
Other Terminations:	Number of spontaneous terminations 1		Number of induced terminations 1		
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1996 2. 2011 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2016 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity			
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Live Births:	Number now living 4	Number now deceased 0			
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1			

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:				

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/06/2016		Education Bachelor's Degree	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					
Live Births:		Number now living 0		Number now deceased 0			
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0			
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____							
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:					
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:					

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 32		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/06/2016		Education Associate Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<p>Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>	<p>Additional Procedure that Terminated Pregnancy</p> <p><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</p> <hr/> <p><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</p> <hr/> <p>For Medical (Surgical) procedures, answer the following question.</p> <p>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the previous question was answered yes, complete the following questions.</p> <p>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</p>
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Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/06/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 21		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/06/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/06/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education 8th Grade or Less		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016		Education Some College, No Degree	
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2013 2. 01/06/2016 3. 4. 5. 6.					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input checked="" type="checkbox"/> Other (<i>Specify</i>) POST-ABORTION HEMATOMETRA Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/27/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/20/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/08/2016		Education Bachelor's Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 1		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 44	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/01/2010 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CASANDRA CASHMAN
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN 46268



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Associate Degree		
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/30/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 33		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/03/2016		Education Doctorate/Professional Degree	
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results: _____			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____</div>
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Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 27		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/04/2016		Education Some College, No Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 2		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36		Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Date of pregnancy termination 06/10/2016		Education Doctorate/Professional Degree	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 1		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 28		Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of pregnancy termination 06/14/2016		Education High School Diploma or GED	
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown				Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:		Number now living 0		Number now deceased 0	
Other Terminations:		Number of spontaneous terminations 0		Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			

Type of Termination Procedures	
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<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>
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Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268	City or town, of pregnancy termination INDIANAPOLIS	County of pregnancy termination MARION
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PPIN-GEORGETOWN OR (PPGI) - 8590 GEORGETOWN ROAD, INDIANAPOLIS, IN, 46268		City or town, of pregnancy termination INDIANAPOLIS		County of pregnancy termination MARION	
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education High School Diploma or GED		
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN 2. 3. 4. 5. 6.					

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/31/2016